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Medicare

Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual

U.S. Department of
Health and Human Services
Health Care Financing Administration
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AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY MANUAL

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OUTPATIENT PHYSICAL THERAPY

AND

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

MANUAL

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FOREWORD

A. Function of the Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual.--This manual makes available to the outpatient physical therapy provider, in a form suitable for ready reference, informational and procedural material needed for the prompt and accurate filing of claims for services furnished under the provisions of the Health Insurance for the Aged Act (Medicare). It also contains information the provider may need to answer questions which patients often ask about the program and should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The provider's intermediary or carrier will issue any necessary additional instructions on matters which concern the relationship between the provider and the intermediary or carrier.

B. Contents and Organization.--The manual provides instructions for implementation of the provisions of Title XVIII of the Social Security Act and Medicare regulations particularly as they relate to the outpatient physical therapy provider benefits. It amplifies the basic statutory provisions for coverage of services and the requirements which must be met for Medicare payment to be made. The procedures and documentation required have been devised to satisfy the administrative needs of the program and are slanted toward the usual case. However, an attempt has been made to cover some infrequent situations that may occur.

The following subjects are included in the manual:

- o General Information About the Program.—A brief description of the scope of Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), and a description of the financing and administration of the Medicare program
- o Coverage of Services.—Details those services reimbursable to providers under the Medicare program and outlines the requirements for payment
- o Billing Procedures.—Detailed guidelines for completing the Provider Billing for Medical and Other Health Services, and Requests for Medicare Payment forms

A table of contents for each chapter provides designated section heads. A detailed index is also included to facilitate locating specific information.

C. Relation Between the Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual and Other Reference Material.--Title XVIII of the Social Security Act is the statutory basis for the Medicare program and is the foundation for the regulations and all manual material.

The health insurance regulations prepared by the Health Care Financing Administration (HCFA) are interpretations, implementations, and policies flowing from the statute and are formally approved and published by the Secretary of the Department of Health and Human Services. Regulations have the force and effect of law and are binding on all parties.

The Health Care Financing Administration also publishes "Health Care Financing Administration Rulings" containing case decisions and interpretations of the law and regulations. The rulings do not apply to other cases when the facts are not substantially the same. Although this manual does not have the effect of regulations, a careful effort has been made to insure that the provisions of the law and regulations are accurately reflected.

The Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual should be used in conjunction with the Provider Reimbursement Manual (HCFA-Pub.15-1) which provides guidelines for computing the reasonable cost of services furnished by outpatient physical therapy providers and other providers.

D. Outpatient Physical Therapy Provider Manual Revisions.--The manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, supplements and revised sections, pages, or chapters are issued as the need presents itself. Changed material is indicated in the left margin of a page in the following manner:

Line on which change begins.

Line on which change ends.

The revision transmittal sheet identifies new page numbers and the pages replaced, and summarizes the principal changes in the material being issued. When a major change in policy or procedures is involved, the background and effective date for the change is provided. If, at a later date, you wish to refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

E. Use of the Revision Transmittal Check Sheet.--Immediately after the title page, a check sheet has been provided on which receipt of revisions can be recorded. Revised manual transmittals should be filed in transmittal number order to avoid discarding a more recent page in favor of an older one.

If it appears that you have been skipped in the distribution of a particular transmittal, keep in mind that the transmittals are not always distributed in strict numerical sequence. Allow 10 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.

F. Effective Dates for Outpatient Physical Therapy Provider Manual Issuances.--Outpatient Physical Therapy Provider Manual transmittals specify whether the material involves a change in policy or procedures, new policy or procedures, or simply a clarification of existing policy or procedures. For new policies or procedures or changes in the old, the transmittals also specify the effective date. New policies or procedures or changes in the old usually carry prospective dates. However, a proposed policy issuance which corrects a prior statement of policy will be given retroactive effect, to be specified on the transmittal. A clarification is intended only to improve the understanding of policies or procedures that are already in effect, and an effective date is not specified.

G. Intermediary as Information Source.--Your intermediary will answer any questions you may have about Medicare policies and procedures.

CHAPTER I

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Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (Title XVIII of the Social Security Act), known as "Medicare" has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs--hospital insurance (HI) (Part A of the law) and voluntary supplementary medical insurance (SMI) (Part B of the law). The 1972 Amendments to the Social Security Act extended this same health insurance coverage to persons under age 65 qualifying as disabled and those having chronic renal disease. The term "chronic renal disease" is used with the understanding that the reference is to chronic renal disease which required hemodialysis or transplantation, as set out in the law. In addition, an individual age 65 or over who wants HI but is not insured for monthly benefits may enroll for such coverage, for which he must pay a premium, if he meets certain requirements and enrolls in SMI.

The social security office should be contacted if there is any question concerning an individual's entitlement under Part A or Part B.

102. FINANCING THE PROGRAM

Part A (Hospital Insurance) is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund which may be used only for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B (Supplementary Medical Insurance) is financed by the monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund may be used only to pay for Part B benefits and administrative expenses.

106. FRAUD AND ABUSE--GENERAL

Fraud in Medicare can be in the form of false claims or bills submitted to carriers and intermediaries (contractors) for medical or health services which were not rendered. Fraud can also be occasioned by the representation on the claim form of more complicated, and hence more costly, procedures than those actually rendered. Another form of fraud is the submission of a false cost report in which costs are intentionally misrepresented or inflated for the purpose of obtaining Medicare reimbursement not due. It is also fraudulent to engage in kickback arrangements in connection with the furnishing of covered items or services.

The term "abuse" is used to describe incidents and practices which, although not considered fraudulent acts, may directly or indirectly cause financial losses to the Medicare program or to beneficiaries and their families. One type of abuse which occurs often in the Medicare program is overutilization of medical and health care services. The Medicare law expressly excludes from coverage any services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. It is considered abuse when there appears to be a definite and repeated pattern of overutilization. Not all incidents of abuse are considered violations in the legal sense and are often disposed of by corrective action by contractors, plus recovery of any overpayment which has resulted.

106.1 Penalties for Fraud and False Reporting.--Whoever knowingly and willfully makes, or causes to be made, a false statement or false representation of a material fact with respect to the conditions and operation of a health facility to permit the facility to qualify and participate as a provider under title XVIII (either in initial certification or recertification) shall be guilty of a misdemeanor punishable by a fine of up to $2,000, or imprisonment for up to 6 months, or both.

Whoever knowingly and willingly makes or causes to be made any false statement or misrepresentation of a material fact in any application for any benefit or payment under the Medicare program, or makes false statements for use in determining rights to such benefit or payment, or has knowledge of the occurrence of any event affecting the right to receive such benefits and fails to disclose such event with the intent to improperly secure benefits when none is due or receive a greater amount than is due, or receives such benefits on behalf of another and converts them to a use other than for the use or benefit of such person, shall be guilty of a criminal offense punishable by fine or imprisonment, or both.

In addition, whoever furnishes items or services and who solicits, offers, or receives any kickback, bribe, or rebate of a fee, shall be guilty of a misdemeanor punishable by a fine of up to $10,000, or imprisonment for up to 1 year, or both.

106.2 Definition of Key Terms.--In determining whether there has been a violation of any statute, there are several terms which must be well understood before they can be applied to a particular act or acts.

A. Intent to Defraud.--The terms "with intent to defraud" and "fraudulently" are synonymous. They refer to an intentional deception or misrepresentation which the individual knows to be false, or which he does not believe to be true, and which he makes knowing that his deception could result in some unauthorized benefit to himself or some other person. The requisite intent is present if the representation was either knowingly false or made in reckless disregard of what the facts might be. Since fraudulent intent, as a subjective element of crime, is difficult to prove by direct evidence, it may be inferred from circumstances and from patterns of actions. Intent to defraud may be imputed to a corporation if an agent of the corporation has such intent in committing the act. Thus, there would seem to be no legal obstacle to successful prosecution of a corporation provided that: (1) the guilt of the individual acting on behalf of the organization can be established; and (2) the act was committed by the individual while performing within the scope of his employment by the corporation.

B. Knowingly.--The term "knowingly" as used in a criminal statute generally means that state of mind which exists when the accused person is in possession of facts under which he is aware that he cannot lawfully do a particular act, but nevertheless proceeds to do it. It is intended to exclude unwitting or unconscious actions contrary to the law, such as mistakes of fact or accidents.

C. Willfully.--The term "willfully" means voluntarily, purposefully, deliberately, and intentionally as opposed to accidentally, inadvertently, or carelessly. It involves actual knowledge of the existence of a legal obligation and the intent to evade that obligation.

D. Material.--The term "material" as applied to a false statement, false representation, or deceitful withholding of information where there is a duty to disclose the truth, means that the deceit must relate to a matter that is of significance and would tend to influence a carrier or intermediary to pay benefits not authorized by the Act, or would otherwise influence a carrier or intermediary in determining rights to, or amount of, payment. The courts have said that the tests of whether a statement is material is the capability of the statement to mislead, rather than whether it was possible for the intended deception to attain its end.

108. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM
The Department of Health, Education, and Welfare has overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Four major agencies of the Department are involved. The Social Security Administration's central office is responsible for policy formulation, and that office, along with its regional offices, is responsible for the general management and operational aspects of the program. The Public Health Service has the principal responsibility for the professional health aspects of the program. The Social and Rehabilitation Service has a primary role in all aspects of program administration affecting public welfare agencies. Each regional office of the Department of Health, Education, and Welfare (DHEW) has a Regional Division of Long Term Care with authority to approve Medicare provider agreements with skilled nursing facilities (SNF's) and to terminate (or decline to renew) agreements when the SNF's do not meet the standards established by the Social Security Act.

110. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL (HIBAC)

The Health Insurance Benefits Advisory Council is a nongovernmental advisory group consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative from the public. HIBAC provides advice and recommendations to the Secretary on general policy in administering the Medicare (title XVIII) and Medicaid (title XIX) programs.

112. STATE AGENCIES

The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

A. Certification.--Facilities desiring to participate in either the Medicare or Medicaid program must meet the conditions of participation to be certified. State agencies make certifications to the Department of Health, Education, and Welfare (DHEW) indicating whether hospitals, skilled nursing facilities, home health agencies, independent laboratories, portable X-ray facilities, and providers furnishing outpatient physical therapy and speech pathology services satisfy, and continue to satisfy, their respective conditions of participation in the Medicare and Medicaid programs. This function of making certifications is intended to be a natural adjunct to ongoing State activities, such as the licensing of health care facilities and the setting of standards.

B. Consultation with providers of services that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. Coordination by the State relates its activities under the program to the other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of these activities is essential in assuring effective and economical use of existing State facilities and trained personnel, and in preventing duplication of effort.

D. State Agency as a Medical Insurance Intermediary.--Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 175, the agreement may provide for a designated State agency to serve as a contractor on behalf of its welfare recipients.

120. ROLE OF PART A INTERMEDIARIES

The Part A intermediary is a public or private agency or organization that has entered into an agreement with the Social Security Administration to process Medicare claims under both Part A and Part B of providers of services, i.e., hospitals, skilled nursing facilities, home health agencies, end-stage renal disease facilities, and also rehabilitation agencies and public health agencies that have been approved to furnish outpatient physical therapy and speech pathology services. (Providers may elect to deal directly with the Social Security Administration.)

Intermediaries make payments to providers; the amount of reimbursement to any provider is restricted to the lesser of (a) the reasonable cost of covered services and items or (b) the customary charges with respect to such services. (See Provider Reimbursement Manual, §§ 2600ff.) In addition, intermediaries assist in the application of safeguards against unnecessary use of covered services, furnish consultative services to assist in the establishment and maintenance of requisite fiscal data, serve as a center for communicating with providers, audit provider records, assist in the beneficiary appeals process, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

125. ROLE OF THE PART B CARRIERS

The law requires the Secretary to enter into contracts with carriers to serve as intermediaries in the operations and administration of the non-provider Part B program. A principal function of these carriers is to determine whether charges of physicians (including facility-based physicians) and suppliers for covered Part B services constitute "reasonable charges" within the meaning of the law, and to make payment. Carriers also make Part B payments on a reasonable cost basis to participating clinics for outpatient physical therapy and speech pathology services furnished to Medicare patients. Other major functions include, for example, controlling overutilization and communicating with the health community.

Carriers are generally assigned to serve a geographical area in which medical services are furnished. All clinic providers located within the geographic area serviced by a Part B carrier will be serviced by that carrier. However, claims of railroad retirement beneficiaries are processed by the Travelers Insurance Company regardless of where the services are furnished, and welfare recipients may be served by a State welfare agency (§ 112).

Provider Participation in Medicare

130. DEFINITION OF PROVIDER

A. Providers of Services.--A provider of services (or provider) is a hospital, skilled nursing facility, home health agency, and for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency, or public health agency which meets the applicable eligibility requirements of title XVIII of the Social Security Act and regulations issued thereunder (i.e., the conditions of participation).

B. Participating Providers.--To be a participating provider qualified to receive payment under Medicare, an outpatient physical therapy provider must enter into an agreement under section 1866 of the Social Security Act which provides that it (1) will not charge any individual or other person for items and services covered by the health insurance program other than deductibles and coinsurance amounts; and (2) will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as described in § 242.

A provider which has executed an agreement becomes qualified to participate after the agreement is accepted for filing. Where the agreement is retroactive, the provider must comply with the terms of the agreement as of the retroactive date. For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a recordkeeping capability sufficient to determine the costs of services furnished to Medicare beneficiaries.

140. ELECTION OF INTERMEDIARY BY REHABILITATION AGENCIES AND PUBLIC HEALTH AGENCIES (See § 125 for clinics.)

A. Newly Participating Provider.--Providers may elect to be served by any intermediary already authorized to serve other providers of the same type in its area. Such elections will be reviewed by the health insurance regional office of SSA (HIRO). They will usually be approved unless special or temporary limitations have been placed on the elected intermediary's availability or it is determined that an addition to the elected intermediary's workload at the time would be undesirable. Questions regarding the availability of an intermediary should be directed to the HIRO.

B. Provider Changing Ownership.--Providers which have undergone a change of ownership will generally continue with the same intermediary that served the previous owner. However, where the new owner requests a different intermediary and the request is approved, the change of intermediary will be effective as follows:

1. If the provider ceased billing effective with the change of ownership, the effective date of the intermediary change will be the effective date of the change of ownership. However, if the effective date of the provider's new certification to participate is determined to be later than the change of ownership, the effective date of the intermediary change will be the new certification date.

2. If you continued billing after the change of ownership, the intermediary change will be effective with the first day of your fiscal year following certification for participation in the program.

C. Change of Intermediary.--If you wish to change your intermediary, give notice to the HCFA RO and to your intermediary at least 120 days prior to the end of your current fiscal year. The request should be signed by an authorized representative and submitted with an explanation to the RO. Since changes of intermediary can be costly and disruptive to the program HCFA will determine, based upon the reasons given and other pertinent factors, if a change is warranted and would contribute to more effective and efficient program operations. Where HCFA approves, the change becomes effective on the first day following the close of the fiscal year in which you gave timely notice.

142. TERMINATION OF PROVIDER PARTICIPATION

You may voluntarily terminate participation in the Medicare program or have it terminated for cause. You continue to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

The 1972 amendments provide authority for the Secretary of DHHS to terminate from participation in the Medicare program any provider found guilty of program abuses. The Secretary is required to make the names of such organizations public so that beneficiaries will be informed about which providers cannot participate in the program. The situations for which termination may be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Any organization dissatisfied with the Secretary's decision to terminate is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

142.1 Voluntary Termination by Outpatient Physical Therapy, Speech Pathology, or CORF Providers.--An outpatient physical therapy or speech pathology provider may terminate its agreement by filing a written notice of its intention with the RO. HCFA may accept the termination date requested (the date must be the first day of a month) or set a different date. However, the termination date set by HCFA shall not be more than 6 months from the date your notice was filed. You will be advised of the effective date and of the need to give notice to the public at least 15 days in advance of the termination date. Information regarding the type of public notice will be furnished by the RO.

An agreement with a provider which goes out of business (i.e, permanently or temporarily ceases to furnish services to the community) terminates effective with the date it goes out of business. If you contemplate going out of business, notify HCFA in advance so that proper notice can be given to the public.

142.2 Involuntary Termination by HCFA.--HCFA may terminate an agreement if it is determined that the provider:

A. Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations; or

B. No longer meets the appropriate conditions of participation; or

C. Has failed to supply information which is necessary to determine whether payments are or were due and the amounts; or

D. Refuses to permit examinations of fiscal and other records, including medical records; or

E. Has knowingly and willfully made, or caused to be made, false statements or representations with respect to facts material to the right to payment; or has submitted, or caused to be submitted, requests for payment for amounts substantially in excess of the costs incurred; or has furnished items or services which are substantially in excess of the individual's needs, are harmful, or are of a grossly inferior quality.

HCFA will give notice of termination to you and the public at least 15 days before the effective termination date. If you are dissatisfied with HCFA's determination, you may request a hearing. After HCFA terminates your agreement you may not file another agreement to participate unless HCFA finds that the reason(s) for termination of the prior agreement have been removed and that there is reasonable assurance that they will not recur.

142.3 Determining Payment for Services Furnished After Termination by an Outpatient Physical Therapy, Speech Pathology, or CORF Provider.--Payment for services furnished under a plan established on or after the termination date, cannot be made except that if the plan was established before the termination date, payment can be made for covered services for up to 30 days following the effective date of termination.

Health Insurance Program

155. HOSPITAL INSURANCE--A BRIEF DESCRIPTION

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care by reimbursing participating providers of services for the reasonable cost of furnishing covered services. In addition to inpatient hospital services, hospital insurance covers the reasonable cost of post-hospital care furnished by participating skilled nursing facilities and home health agencies.

160. SUPPLEMENTARY MEDICAL INSURANCE (SMI)--A BRIEF DESCRIPTION

To obtain SMI, an eligible individual must enroll during an enrollment period and pay the required premiums. The individual is eligible to enroll if entitled to HI, or is 65 years of age and a resident citizen or an alien who meets certain residence requirements.

The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides reimbursement (after a yearly cash deductible has been met) for 80 percent of the reasonable charge (or of the reasonable cost if the service is furnished by a participating provider of services) for the following specified medical and other health services:

A. Physicians' services including surgery, consultation, and home, office and institutional calls.

B. Services and supplies as follows:

o Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill.

o Hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

o Diagnostic services which are furnished on an outpatient basis by the hospital or others furnishing the services under arrangements, and ordinarily furnished by the hospital (or others under arrangements) to outpatients for diagnostic study.

C. Diagnostic X-ray, laboratory, and other diagnostic tests.

D. X-ray, radium, and radioactive isotope therapy, including material and services of technicians.

E. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

F. Rental or purchase of durable medical equipment (iron lungs, oxygen tents, wheelchairs, special beds) for use in the patient's home or place considered to be his residence.

G. Ambulance service, where the use of other transportation is contraindicated by the patient's condition.

H. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.

I. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, eyes, including replacements if required because of a change in the patient's physical condition.

J. Outpatient physical therapy, occupational therapy, or speech pathology services furnished by or under arrangements made by participating providers of services (including clinics, rehabilitation agencies, and public health agencies). Coverage also includes the services of a qualified physical therapist or occupational therapist in independent practice when furnished in his office or the beneficiary's home; expenses incurred for such services in a calendar year may not exceed $500.

Medical insurance also supplements the basic hospital insurance coverage by providing reimbursement for additional home health care.

Disclosure of Information

190. DISCLOSURE OF HEALTH INSURANCE INFORMATION--GENERAL

Records and information acquired in the administration of the Social Security Act may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Administrator of HCFA. Regulations regarding the disclosure of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. Such information includes the individual's health insurance claim number, facts regarding his entitlement to health insurance benefits, and medical and other information obtained from HCFA or an intermediary or carrier (contractor).

However, the information in the provider's own records of a patient (e.g., name, date of birth, sex, marital status, address, medical records) is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. The provider's own records, however, are subject to the requirements in the "Conditions of Participation; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and/or Speech Pathology Services; and Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physicial Therapists in Independent Practice (HIRM-1)" that patients' medical records be kept confidential. These records may also be subject to State or local laws governing disclosure.

When a provider receives a request for information about a Medicare beneficiary, a Medicare claim, or related information which it may not disclose, the inquirer should be referred to the appropriate contractor for further consideration of his request.

191. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY, OR IN CONNECTION WITH A CLAIM

191.1 Disclosure to the Beneficiary or His Authorized Representative.--

A. General.--Information directly relating to the beneficiary, such as Medicare entitlement or eligibility data, may be disclosed to the individual or his authorized representative (including his representative payee).

B. Medical Information.--Providers may not forward medical information to contractors on a confidential basis, expressed or implied, since under the Privacy Act any medical information obtained by a contractor is subject to disclosure to the individual to whom it pertains, or to another person authorized by the individual to have access to it.

Some providers document findings on medical forms preprinted "confidential," or routinely stamp all records "confidential," whether or not such records are ever intended for disclosure to a contractor. Such records, when transmitted to the contractor, will be accepted only if accompanied by a signed statement that the provider understands the information is subject to disclosure to the patient under the Privacy Act and any words or statements that the transmitted records are confidential may be disregarded if the patient or his representative requests them from the contractor or from HCFA. The repeated preparation and forwarding of separate signed statements can be obviated if the provider signs an appropriate general statement of understanding with the contractor that medical information may be disclosed to the individual under the Privacy Act, even if it is routinely designated "confidential."

191.2 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.--Disclosure of any record, report, or other information about an individual is authorized without the consent of the individual in connection with any claim or other proceeding under the Social Securty Act only when disclosure is necessary for the proper performance of the duties of:

A. Any officer or employee of the Department; or

B. Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

191.3 Disclosure to Third Parties for Other Than Program Purposes.--Information obtained from HCFA or its intermediary is confidential and may be disclosed only under conditions prescribed in rules and regulations, or on the express authorization of the Administrator of the Health Care Financing Administration. However, certain limited information about the Medicare eligibility status of beneficiaries and related claims information may be released to third party payers with the beneficiary's express authorization.

A. Information Which May Be Released.--Subject to necessary authorization, only the following records may be released:

1. beneficiary health insurance claim number;

2. coinsurance and deductible;

3. dates of entitlement to Medicare;

4. copies of Medicare claims forms;

5. Medicare report of eligibility;

6. Explanation of Medicare Benefits (EOMB);

Requests for other information desired for complementary insurance purposes should be referred to the intermediary.

B. Form of Authorization.--Make certain that information is not released without the required authorization. The authorization must:

1. be in writing;

2. be signed and dated by the individual or someone authorized to act in his behalf;

3. specify the name of the provider being authorized to disclose information;

4. specify what information the individual is authorizing the provider to disclose;

5. specify the names of the third party payers to whom the information is being released;

6. specify the purpose for which the information is being released; and

7. specify an expiration date for the authorization which should not exceed 2 years from the date it was signed and specify that it may be revoked at any time.

191.4 Claims for Payment in Alcohol and Drug Abuse Cases.--The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients than when disclosing information for other Medicare beneficiaries. Since the standard consent statement on the provider billing form is not sufficient authority under the law to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers participating in Medicare and alcohol and drug abuse prevention and treatment programs must obtain written consent from beneficiaries to release medical information in each alcohol or drug abuse case. This written consent, which will allow the provider to disclose the records of the patient, should include all of the following:

1. The name of the organization (hospital, etc.) which is to make the disclosure;

2. The name or title of the person or organization to which disclosure is to be made (e.g., the Health Care Financing Administration, including the appropriate intermediary or carrier, specified by name);

3. The name of the patient;

4. The purpose or need for disclosure (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is legally and administratively required in the overall conduct of the Medicare program);

5. The specific extent or nature of information to be disclosed (e.g., all medical records regarding the beneficiary's treatment, hospitalization and/or outpatient care including treatment for drug abuse or alcoholism);

6. A statement that the beneficiary may revoke his consent at any time to prohibit disclosures on or after date of revocation;

7. A statement specifying a date (not to exceed 2 years), event, or condition upon which consent will expire without revocation;

8. The date on which the consent is signed;

9. The signature of the patient; or the signature of his authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program, such as a PSRO, as appropriate. Authorization may also be given to HCFA and its contractors to redisclose specific information to third party payers for complementary insurance purposes. (See §191.3 above.)

The provider should keep the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years, after which it must be renewed by the beneficiary if further disclosures are necessary.

192. DISCLOSURE OF INFORMATION ABOUT PROVIDERS BY HCFA

The following information about providers participating in the Medicare program may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

192.1 Medicare Reports.--

A. Provider Survey Report and Related Information.--Information concerning survey reports of providers, as well as statements of deficiencies, based on survey reports completed after January 31, 1973, are available at the local social security office or the public assistance office in the area where the facility is located. The following data may be released under this provision:

1. The official Medicare report of a survey concluded on or after January 31, 1973;

2. Statements of deficiencies which have been conveyed to the provider following a survey concluded on or after January 31, 1973;

3. Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey concluded on or after January 31, 1973.

State agencies certify whether institutions or other entities meet the Medicare conditions of participation for outpatient physical therapy and speech pathology providers. (See §112.) A State agency may disclose information it obtains relating to the qualifications and certification status of providers it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of providers completed after January 31, 1973, are made available to the public. After the survey reports and other formal evaluations are prepared by personnel of the Health Care Financing Administration, the evaluated provider must be given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The provider's comments must be incorporated in the report if pertinent.

Program validation review reports are generally released from the Bureau of Health Insurance regional office serving the area in which the provider is located.

Generally, informal reports and other evaluations of the performance of providers which are prepared by the contractor are available to the public.

C. Provider Cost Reports.--

1. General.--Requests by any member of the public either to inspect or to obtain a copy of a provider cost report must be submitted to SSA or the contractor in writing and must identify the provider and specific cost report(s) in question.

Contractors are required to respond to requests in writing within 10 working days after receipt of a written request, to advise the requestor of the date the reports will be made available. That date will be no earlier than 10 working days from the date of the contractor's response. A copy of the response to the requestor will be sent simultaneously to the provider putting the provider on notice that its report has been requested by a particular person. If a request is for a report submitted by a former owner of a provider, copies of the contractor's response to the requestor will go to both the present owner and the former owner of the provider. If the request is for a report submitted by a provider no longer participating in the Medicare program, a copy of the contractor response will be sent to the provider. In the case of both a former owner and a former participating provider, the copy of the response will be sent to the last known address of the party.

2. Information That May be Disclosed.--Disclosure by the contractor is limited to cost report documents which providers are required by SSA regulations and instructions to submit and, in case of a settled cost report, the contractor's notice of program reimbursement. These documents include the statistical page, the settlement pages, trial balance of expenses, and cost finding schedules or documents required by SSA as part of the regular cost report process. (Where a provider, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, these documents are subject to the same disclosure rules as official forms.)

If a request is received to inspect or to obtain a copy of a report that has not been settled, i.e., the final settlement notice of program reimbursement has not been sent, the contractor will disclose a copy of the report as submitted by the provider. If settlement has been made, the contractor will disclose the settled report. If a requestor specifically asks for both the settled and unsettled cost reports of a provider, the contractor will comply with such request. When a report is made available for inspection or copying, it will be clearly marked with one of the following captions, as applicable:

a. Cost report as submitted

b. Settlement subject to audit

c. Audited settlement

When a contractor discloses a settled report, schedules applicable to the settlement that have been reworked by the contractor are disclosable. The general rule is that if the contractor has reworked any of the schedules that were required to be submitted by the provider with its original submission, these schedules become an integral part of the report for disclosure purposes. However, any details containing contractor or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the provider's operation are not disclosed by the contractor.

Information obtained in auditing provider cost reports and other financial records may be released by SSA.

3. Information That May Not be Disclosed.--If a provider chooses to submit with its cost report additional information not specifically required by regulations or instructions, the contractor will not disclose such information unless it is contained within an official document. For example, some providers may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required in accordance with cost reporting instructions), or income tax returns, etc., that are not required by the program. These items would not be disclosed by the contractor as part of the cost report.

Except where a provider has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the contractor requires the provider to submit in support of its cost representations would also not be disclosed by the contractor as part of the cost report. In addition, the following are not disclosed by the contractor as part of a cost report: audits, schedules, letters, notes, general comments; comments on results of **desk reviews (including copies of the actual desk review documents)**, contractor notices and comments (including transmittal letters), audit adjustment summaries that are required to be prepared by contractors and auditors, and information pertaining to an individual patient.

NOTE: Any of the information indicated above that is not to be disclosed by the contractor may be subject to disclosure under the Freedom of Information Act upon review by the Health Insurance Regional Office, Central Office, or a U.S. District Court in response to a request for such information. The description of what will be made available by a contractor as part of a cost report pertains only to requests that indicate that the requestor specifically wants cost reports.

192.2 Disclosure of Medicare Statistics.--Numerous statistics on individual providers are available to the public. They include, but are not limited to, the following:

1. Waiver of liability statistics

2. Interim rate payment data

3. Amount of Medicare reimbursement

4. Overpayment data

5. Data from the Provider Monitor Listing

6. Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services

192.3 Other Information That May be Disclosed.--

1. Presumptive waiver of liability status of the provider;

2. Information as to whether a provider participates in the Medicare program.

193. COST TO A PROVIDER WHICH REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

Providers are required to pay appropriate fees for information they may request pertaining to other providers, Medicare contractors, or State agencies. A provider may claim such fees as allowable costs only if it demonstrates to the contractor the information is necessary in developing and maintaining the operations of patient care facilities and activities.

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Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services

200. OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES FURNISHED BY PROVIDERS

Outpatient physical therapy, occupational therapy, and speech pathology services are covered under the medical insurance program (Part B). Patients with medical insurance coverage are entitled to have payment made on their behalf for 80 percent of the reasonable cost of these outpatient services when furnished by a participating provider of services or by others under arrangements with and under the supervision of such a provider. A participating provider of services is a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency which has entered into an agreement with the Secretary of Health and Human Services to participate in the Medicare program.

202. SERVICES FURNISHED UNDER ARRANGEMENTS WITH PROVIDERS

A provider of services may have others furnish outpatient physical therapy, occupational therapy, or speech pathology services through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. However, in permitting the provider to furnish such services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for such services to be covered the provider must assume professional responsibility for the services. The provider's professional supervision over the services requires application of many of the same controls as are applied to services furnished by salaried employees.

The provider must accept the patient for treatment in accordance with its admission policies, maintain a complete and timely clinical record of the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and see to it that the medical necessity of such service is reviewed on a sample basis by the agency's staff or an outside review group.

When a clinic, rehabilitation agency, or public health agency provides outpatient physical therapy, occupational therapy, or speech pathology services under an arrangement with others, the services must be furnished in accordance with the terms of a written contract, which provides that the clinic or agency retains responsibility for and control and supervision of such services. The terms of the contract must at least:

- Provide that the services are to be furnished in accordance with the plan of care (see §205.3);
- Specify the geographical areas in which the services are to be furnished;
- Provide that personnel and services contracted for meet the same requirements as those which would apply if the personnel and services were furnished directly by the clinic, rehabilitation agency, or public health agency;
- Provide that the therapist will participate in conferences required to coordinate the care of an individual patient;
- Provide for the preparation of treatment records, with progress notes and observations, and for their prompt incorporation into the clinical records of the clinic or agency;
- Specify the financial arrangements. The contracting organization or individual may not bill the patient or Medicare; and
- Specify the period of time the contract is to be in effect and the manner of termination or renewal.

205. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR SPEECH PATHOLOGY SERVICES

Outpatient physical therapy, occupational therapy, or speech pathology services furnished a beneficiary by a participating provider are covered only when furnished in accordance with the following conditions.

205.1 Physician's Certification and Recertification.—

A. Content of the Physician's Certification.—No payment may be made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that:

- A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician (see §205.3);
- The services are or were furnished while the patient was under the care of a physician (see §205.2); and
- The services are or were required by the patient.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify to the necessity for the services. Certification should be obtained at the time the plan of treatment is established or as soon thereafter as possible. "Physician" means a doctor of medicine, osteopathy (including an osteopathic practitioner) or podiatric medicine legally authorized to practice by a State in which he performs the function. The services performed by physicians within this definition are subject to any limitations imposed by the State on the scope of practice. In addition, the performance of these services by a doctor of podiatric medicine must be consistent with the policies of the institution or agency with respect to which he performs them.

B. Recertification.--When services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual clinic or agency.

C. Method and Disposition of Certifications.--There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the contractor can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the provider, but the provider must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file when the request for reimbursement is forwarded.

D. Delayed Certification.--The provider should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the provider considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained will be left to the provider.

205.2 Outpatient Must be Under the Care of a Physician.--Outpatient physical therapy, occupational therapy, or speech pathology services must be furnished to an individual who is under the care of a physician. There must be evidence in the clinical record of the patient that he has been seen by a physician at least every 30 days. If the patient has not been seen by the physician within a 30-day period, the provider is responsible for contacting the physician. This physician may be the patient's private physician, a physician on the provider's staff, a physician associated with an institution which is the patient's residence, or a physician associated with a medical facility in which the patient is an inpatient. The attending physician establishes or reviews the plan of treatment and also makes the necessary certifications.

205.3 Outpatient Physical Therapy, Occupational Therapy or Speech Pathology Services Furnished Under a Plan.--Outpatient physical therapy, occupational therapy, or speech pathology services must be furnished under a written plan of treatment established by:

- a physician after any necessary consultation with the physical therapist, occupational therapist, or speech pathologist, as appropriate;
- the physical therapist who will provide the physical therapy services;
- the occupational therapist who will provide the occupational therapy services; or
- the speech pathologist who will provide the speech pathology services.

The plan must be established (that is, reduced to writing either by the person who established the plan or by the provider when it makes a written record of that person's oral orders) before treatment is begun. The plan should be promptly signed by the ordering physician, therapist, or speech pathologist and incorporated into the provider's permanent record for the patient.

The plan must relate the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech pathology services that are to be furnished the patient and indicate the diagnosis and anticipated goals. Any changes to this plan must be made in writing and signed by the physician, therapist, or pathologist. Changes to the plan may also be made pursuant to oral orders given by the attending physician to a qualified physical therapist (in the case of physical therapy services), a qualified occupational therapist (in the case of occupational therapy services), a qualified speech pathologist (in the case of speech pathology services), a registered professional nurse, or a physician on the staff of the provider.

Changes to such plans also may be made pursuant to oral orders given by the speech pathologist to another qualified speech pathologist, by the occupational therapist to another qualified occupational therapist, or by the physical therapist to another qualified physical therapist, or by the therapist or pathologist to a registered professional nurse on the staff of the provider. Such changes must be immediately recorded in the patient's records and signed by the individual receiving the orders. While the physician may change a plan of treatment established by the pathologist or therapist providing such services, the therapist or pathologist may not alter a plan of treatment established by a physician.

The plan must be reviewed by the attending physician, in consultation with the physical therapist(s), occupational therapist(s), or speech pathologist(s) of the provider, at such intervals as the severity of the patient's condition requires, but at least every 30 days. Each review of the plan should contain the initials of the physician and the date performed. The patient's plan normally need not be forwarded with the claim but will be retained in the provider's file. The provider must certify on the billing form that the plan is on file. (See §315.1, Item 22 and §320.2, Item 14.)

205.4 Outpatient Requirement.—Outpatient physical therapy, occupational therapy, and speech pathology services are covered when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other health facilities. In addition, coverage includes physical therapy, occupational therapy, and speech pathology services furnished by participating hospitals and skilled nursing facilities to those of their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of outpatient physical therapy, occupational therapy, and speech pathology services that have inpatient facilities, other than participating hospitals and skilled nursing facilities, may not furnish covered outpatient services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of outpatient physical therapy, occupational therapy, and speech pathology services may furnish such services to inpatients of another health facility.

While outpatient physical therapy, occupational therapy, and speech pathology services are covered when furnished in the home, when added expense is caused by a visit to the home, a question must be raised as to whether the rendition of the service in the home is reasonable and necesary. Where the patient is not confined to his home, such added expense cannot be considered as reasonable and necessary for the treatment of an illness or injury since the home visit is more costly than the medically appropriate and realistically feasible alternative pattern of care; e.g., in the facility's outpatient department. Consequently, these additional expenses incurred by providers due to travel to a person who is not homebound are not covered.

205.5 Covered Physical Therapy Services.--

A. General.-- To be covered physical therapy services the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. Effective July 18, 1984 a plan of treatment for outpatient physical therapy services may be established by either the physician or the qualified physical therapist providing such services. Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical therapy services for Medicare purposes.

Services furnished beneficiaries must constitute physical therapy where entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical therapy services, payment can be made only for those services which constitute physical therapy.

B. Reasonable and Necessary.-- To be considered reasonable and necessary the following conditions must be met:

(a) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition,

(b) The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision. Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary physical therapy services, even if they are performed or supervised by a physical therapist. (When the intermediary determines the services furnished were of a type that could have been safely or effectively performed only by a qualified physical therapist or under his supervision, it will presume that such services were property supervised. However, this assumption is rebuttable and if in the course of processing claims, the intermediary finds that physical therapy services are not being furnished under proper supervision, the intermediary will deny the claim and bring this matter to the attention of the Division of Survey and Certification of the HCFA regional office.)

(c) There must be an exception that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

(d) The amount, frequency, and duration of the services must be reasonable.

NOTE: Claims for physical therapy services denied because they are not considered reasonable and necessary are excluded by section 1862(a)(1) and are thus subject to consideration under the waiver of liability provision in § 1879 of the act. (See § 315B.)

1. Restorative Therapy.-- To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness it is determined that the expectations will not materalize the services will no longer be considered reasonable and necessary; and they, therefore, should be excluded from coverage under section 1862(a)(1).

2. Maintenance Program.-- The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level.

In such situations, the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel, e.g., aides or nursing personnel (or family members where physical therapay is being furnished on an outpatient basis) in carrying out the program and such infrequent reevaluations as may be required would constitute physical therpay.

Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance porgram required and instructed the patient, supportive personnel (or family members where physical therapy is being furnished on an outpatient basis) in the carrying out of the program. Therefore, when a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under § 1862(a)(1).

C. Application of Guidelines.-- The following discussion illustrates the application of the above guidelines to the more common modalities and procedures utilized in the treatment of patients:

1. Hot Pack, Hydrocollator, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.—Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge, and judgement of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

2. Gait Training.—Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assistive walking, such as provided in support for feeble or unstable patients are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist.

3. Ultrasound, Shortwave, and Microwave Diathermy Treatments.—These modalities must always be performed by or under the supervision of a qualified physical therapist and therefore such treatments constitute physical therapy.

4. Range of Motion Tests.—Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy.

5. Therapeutic Exercises.—Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist or by a qualified physical therapy assistant under the general supervision of a qualified physical therapist due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidence by physical therapy notes showing the degree of motion lost and degree to be restored) and such exercises, either because of their nature or the condition of the patient, may only be performed safely and effectively by or under the supervision of a qualified physical therapist. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see B.2.) do not require the skills of a qualified physical therapist.

205.6 Speech Pathology.—

A. General.—Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must relate directly and specficially to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist.

B. Reasonable and Necessary.--Speech pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

2. The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist. (See 42 CFR 405.1202(u)(1)(2).) (When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only by qualified speech pathologists or under the supervision of a qualified speech pathologist, it should presume that such services were properly supervised. However, this assumption is rebuttable and, if in the course of processing claims the intermediary finds that speech pathology services are not being furnished under proper supervision, the intermediary should deny the claim and bring this matter to the attention of the Divison of Health Standards and Quality of the HCFA regional office.)

3. There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and

4. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (The intermediary should consult with local speech pathologists or the State chapter of the American Speech-Language-Hearing Association in the development of any utilization guidelines.)

Claims for speech pathology services which are not reasonable and necessary should be considered denied under authority of section 1862(a)(1) and, therefore, are subject to the waiver of liability provisions in section 1879 of the act. (See § 315B.)

C. Application of Guidelines.—The following discussion illustrates the application of the above guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue.

1. Restorative Therapy.—If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectations will not materialize, the services will no longer constitute covered speech pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under §1862(a)(1).

2. Maintenance Program.—After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech pathologist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech therapy. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under §1862(a)(1).

If a patient has been under a restorative speech pathology program, the speech pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under §1862(a)(1) since the maintenance program should have been established during the active course of treatment.

D. Types of Services.--Speech pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation and therapeutic services.

1. Diagnostic and Evaluation Services.--Unless excluded by §1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology. However, monthly reevaluations, e.g., a Porch Index of Communicative Ability (PICA) for a patient undergoing a restorative speech pathology program, are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes.

2. Therapeutic Services.--The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy:

a. Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

b. Neurological disease such as Parkinsonism or Multiple Sclerosis may exhibit dysarthria, dysphagia, or inadequate respiratory volume/control;

c. Mental retardation with disorders such as aphasia or dysarthria; and

d. Laryngeal carcinoma requiring laryngectomy resulting in aphonia may warrant therapy of the larynegectomized patient so he can develop new communication skills through esophageal speech and/or use of the electrolarynx.

NOTE: Many patients who do not require speech pathology services as defined above do require services involving nondiagnostic, nontherapeutic, routine, repetitive, and reinforced procedures or services for their general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicare purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.

205.7 Covered Occupational Therapy Services.--Occupational therapy services are covered under the guidelines in §403.3.

210. DEDUCTIBLE AND COINSURANCE UNDER MEDICAL INSURANCE

210.1 Deductible.—In each calendar year a cash deductible must be satisfied before payment can be made under the supplementary medical insurance program.

As of January 1, 1982, the deductible is $75.

From 1973 through 1981, the deductible was $60.

From 1966 through 1972, the deductible was $50.

Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for the year in which they were incurred, may also be credited towards the deductible for the following year.

Note: This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

Expenses count toward the deductible on the basis of incurred rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his insurance coverage begins after the first month or if he dies before the last month of the year, he is still subject to the full cash deductible. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance may not be credited toward the deductible.

Before charging the patient for any part of the deductible, the provider should attempt to ascertain whether the patient has already satisfied the deductible for the current calendar year (see §310).

210.2 Coinsurance.—After sufficient expenses have been incurred to satisfy the deductible, the provider will be reimbursed by the program for 80 percent of the reasonable cost of the covered services which it provided directly or through arrangements with others. The patient is responsible for a coinsurance amount of 20 percent of the reasonable charge for the services furnished.

General Exclusions From Coverage

230. GENERAL EXCLUSIONS

No payment can be made under the health insurance program for certain items and services as indicated in the following sections (§§ 231-239).

231. SERVICES NOT REASONABLE AND NECESSARY

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

232. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE SERVICES

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free X-rays or immunizations provided by health organizations.

However, Medicare coverage is not excluded where a third party, rather than the beneficiary is obligated to pay for or provide the items and services. Furthermore, reimbursement is not precluded merely because a provider waives the charge in the case of a particular patient or class of patients. The waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services other than those paid for directly or indirectly by a governmental entity. (For a discussion of the latter, see § 233.4.)

232.1 Indigency.--This exclusion does not apply where items and services are furnished an indigent individual without charge because of his inability to pay, if the provider bills other patients to the extent that they are able to pay.

232.2 Provider Bills Only Insured Patients.--Some providers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation benefits are payable for services rendered to Medicare patients. The same holds true when treatment is financed by a private research foundation and the patient is not expected to pay for his treatment unless he has insurance.

232.3 Medicare Patient Has Other Health Insurance.--Payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. The plan may pay money toward the cost of the services, such as a health insurance policy, or it may organize and maintain its own facilities and professional staff, such as employer and union sponsored plans and group practice prepayment plans.

232.4 Third Party Liability.--There is no provision in the Medicare law for subrogation or any other form of reimbursement to Medicare by liable third parties. Therefore, services are covered by Medicare even though the beneficiary's need for them resulted from the fault or negligence of another party who is legally liable for the patient's medical expenses, or who has, in fact, reimbursed the beneficiary for the expenses for such services. The existence of the other party's liability does not affect the beneficiary's obligation to pay for the services he receives. For example, hospital or other provider services needed because of an automobile accident are covered by Medicare even though a liability insurer (including a no-fault insurer) is legally obligated to pay for them. Similarly where a defective medical device such as a cardiac pacemaker is replaced under a warranty, hospital or other provider services rendered by parties other than the warrantor are covered despite the warrantor's liability. However, payment for the replacement device itself may not be made since, in view of the warranty, no charge could be made for the device.

232.5 Members of Religious Orders.--A legal obligation to pay exists where a religious order either pays for or furnishes services to members of the order. Although medical services furnished in such a setting would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members. Thus, payment may be made for such services whether they are furnished by the order itself or by independent sources that customarily charge for their services.

233. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES

The Medicare law limits the circumstances under which payment may be made for items and services furnished or paid for by State, local or Federal government instrumentalities. The law applies separate limitations applicable to items and services which the provider is obligated under a Federal Government contract or law to furnish at public expense (see § 233.2) and items and services paid for directly or indirectly by a State, Federal, or local government entity (see § 233.3).

The following sections discuss these limitations in greater detail and how they are to be applied under various circumstances.

233.1 Items and Services Furnished by a Federal Provider of Services.--Payment may not be made for services furnished by a Federal provider except for (a) covered emergency services, and (b) items or services furnished by a Federal provider which is determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

For this purpose, a provider acquired by the Department of Housing and Urban Development (DHUD) as an interim measure to conserve the facility's assets pending a sale of the property is not considered to be a Federal provider of services. Accordingly, Medicare payment may be made for services furnished by such DHUD-owned providers whether or not the provider is serving the public generally.

233.2 Items and Services Which the Provider or Supplier Is Obligated to Furnish Under a Federal Government Contract or Law.--Payment may not be made for items or services which a provider is obligated to render at public expense by law of, or contract with, the United States.

233.3 Items and Services Which are Paid for Directly or Indirectly by a Government Entity.--

A. General.--Benefits are not payable for items and services paid for by a State, local or Federal government agency, except as specified in B. and C. below. This exclusion applies to services furnished by governmental facilities as well as services furnished by nongovernmental facilities which are paid for by a governmental agency.

B. Statutory Exceptions.--The exclusion of items and services paid for by a governmental entity does not apply in the following situations; therefore, payment may be made under Medicare where:

1. The items or services are furnished under a health benefits or insurance plan established for employees of the governmental entity;

2. The items or services are furnished under one of the titles of the Social Security Act (such as medical assistance under title XVI or XIX).

C. Exceptions Approved by the Secretary.--The Secretary of Health, Education, and Welfare is authorized by law to specify additional exceptions to this exclusion. The Secretary has approved Medicare payment for items or services which are paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent.

233.4 Illustrations of Exclusions of Services Covered by Various Governmental Programs.--

A. Veterans Administration.--Services furnished without charge by a VA facility are excluded from coverage under Medicare. In addition, the fact that a beneficiary is eligible to have services furnished by private sources paid for by the VA precludes payment for them under Medicare. It will generally be advantageous for health insurance beneficiaries to have services paid for under a VA program where possible since the VA has no deductible or coinsurance requirements.

B. Government Research Grants.--A beneficiary who would be eligible to have his care paid for by a governmental research grant can receive benefits under title XVIII if the facility charges those patients who have Medicare or other insurance. Where a provider claims benefits under title XVIII, it may not also accept research grant funds for the services in question, except to the extent of the deductible and coinsurance amounts.

C. Vocational Rehabilitation Agencies.--Under the vocational rehabilitation programs of the various States, vocational training and services are provided to handicapped persons who qualify under State law. Where items or services are furnished or paid for by a State VR agency, title XVIII benefits are payable only if the agency makes services available without cost because of the individual's medical indigency or as a means of controlling infectious diseases.

D. State or Local Health Department Clinics.--Many State or local health departments operate outpatient clinics. Services rendered by such clinics free of charge because of the individual's indigency or as a means of controlling infectious diseases (e.g., city-operated charity clinics) are covered under title XVIII.

E. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Veterans Administration).--

1. General.--CHAMPUS and CHAMPVA are similar programs administered by the Department of Defense, except that the Veterans Administration determines the eligibility of persons seeking to establish entitlement to CHAMPVA coverage. CHAMPUS provides benefits for health care services furnished by civilian providers, physicians, and suppliers to retired members of the Uniformed Services and to spouses and children of active duty, retired, and deceased members. The term "Uniformed Services" includes the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Oceanic and Atmospheric Administration. CHAMPVA provides similar benefits for spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who died of service-connected disabilities.

2. Effect of Medicare Eligibility on CHAMPUS/CHAMPVA Entitlement.--CHAMPUS/CHAMPVA beneficiaries, other than dependents of active duty members, lose their entitlement to CHAMPUS/CHAMPVA if they qualify for Medicare Part A on any basis other than the premium-HI provisions (see § 100). Individuals who are eligible for Medicare Part B benefits only, as well as dependents of active duty members, are also eligible for CHAMPUS/CHAMPVA benefits.

3. Medicare-CHAMPUS/CHAMPVA Relationship.--CHAMPUS/CHAMPVA will reduce its liability in all cases by the amount payable by Medicare, i.e., Medicare will be the primary payer and CHAMPUS/CHAMPVA will supplement Medicare by paying the Medicare deductible and coinsurance amounts and portions of the bill not covered by Medicare. Thus, dually entitled individuals may be reimbursed up to 100 percent of expenses for items and services covered by both programs.

F. Active Duty Members of the Uniformed Services.--In limited circumstances, active duty members of the Uniformed Services may have care in civilian facilities paid for by the Army, Navy, Air Force, Marine Corps, or other appropriate uniformed service. Except for emergency services, prior approval is generally required before such payment can be made. Services furnished pursuant to such approval and services paid for or expected to be paid for by the Uniformed Services are not reimbursable under Medicare.

234. SERVICES NOT PROVIDED WITHIN THE UNITED STATES

Services (except for inpatient hospital services in specified situations) which are not provided within the United States are not covered. The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

235. SERVICES RESULTING FROM WAR

Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

236. ITEMS AND SERVICES UNDER A WORKMEN'S COMPENSATION LAW

Items and services to the extent that payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State may be paid for by the program. (See § 245ff.)

237. ROUTINE SERVICES AND APPLIANCES

Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

238. CHARGES IMPOSED BY IMMEDIATE RELATIVES OF THE PATIENT OR MEMBERS OF HIS HOUSEHOLD

A. General.--Payment may not be made for expenses which constitute charges by immediate relatives of the beneficiary or by members of his household. The intent of this exclusion is to bar Medicare payment for personal services of physicians or suppliers which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Payment may be made, however, for reasonable charges imposed on such individuals by a physician or supplier to recover out-of-pocket expenses he has incurred in furnishing covered items or supplies, e.g., expenses for covered drugs and biologicals, prosthetic devices, etc. In such cases, the charge may not exceed the physician's or supplier's actual out-of-pocket costs.

B. Services of Providers and Provider-Based Physicians.--This exclusion applies only to services reimbursed on a charge basis and does not apply to provider services and to the services of group practice prepayment plans which are reimbursed for their costs rather than charges. Thus, reimbursement may be made for covered services furnished by a provider to an owner of the institution or to an immediate relative of an owner, or a member of an owner's household.

Reimbursement may not be made, however, for the professional component of services of provider-based physicians furnished to an immediate relative of the physician or to a member of the physician's household. Since the personal services of provider-based physicians are billed on a charge basis, they are subject to this exclusion whether the bill is submitted by the physician or, with his authorization, by the provider.

C. Immediate Relative.--The following are included within the definition of "immediate relative":

- o Husband and wife;
- o Natural parent, child, and sibling;
- o Adopted child and adoptive parent;
- o Stepparent, stepchild, stepbrother, and stepsister;
- o Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; and
- o Grandparent and grandchild.

NOTE: It has been deemed for program purposes that a brother-in-law or sister-in-law relationship does not exist between a physician (or supplier) and the spouse of his wife's (husband's) brother or sister.

A father-in-law or mother-in-law relationship does not exist between a physician and his spouse's stepfather or stepmother.

D. Members of the Patient's Household.--These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

E. Charges by Business Organizations Such as Suppliers and Clinics.--Charges imposed by a medical group, clinic or supplier which is not a corporation are, in effect, imposed by the owner or owners of the business. Thus, this exclusion applies where such a firm is owned by a sole proprietor who bears one of the excluded relationships to the patient or, in the case of a partnership, where all partners are within the excluded relationships. Since a corporation is a separate legal entity, the charges it imposes are not subject to this exclusion regardless of the relationship of the patient to the corporation's owner or owners.

239. PERSONAL COMFORT ITEMS

Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

The provider submitting claims under this procedure indicates on the claim form that it has obtained the patient's signature, by checking the block "Signature contained in the provider records," or, if the form does not contain such a block, by entering "Patient's request for payment in file" on the patient's signature line of the claim. A physician or medical group submitting claims under this procedures indicates that the provider has obtained the patient's signature, by entering on the patient signature line of the claim, "Patient's request for payment on file in (name of provider)."

In using this procedure, the provider, physician or medical group undertakes:

1. To complete and submit promptly the appropriate Medicare billing form whenever it furnishes services to a Medicare beneficiary - even in those cases in which assignment is not accepted for the physician services.

2. To incorporate, by stamp or otherwise, information to the following effect on any bills it sends to Medicare patients: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent patients from submitting duplicate claims.

The provider also undertakes to make the patient signature files available for carrier and intermediary inspection on request.

In the case of clinics, the carrier will make periodic audits of signature files selected on a random basis. In the case of rehabilitation agencies or public health agencies, such audits will be made by the intermediary and, if physician services are covered by the signatures, by the carrier as well. However, the carrier may arrange with the intermediary for the latter to perform this function on its behalf.

240.3 Time Limitation on Filing Claims for Outpatient Physical Therapy and Speech Pathology Services.-- Effective with claims filed after December 31, 1974, the beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished. For example, a claim for services rendered September 30, 1974, must be filed by December 31, 1975. A claim for services rendered October 1, 1974, must be filed by December 31, 1976.

No reimbursement can be made for claims filed after the time limitation except under the following conditions:

1. Where failure to file a timely claim was due to SSA, HCFA, Carrier or intermediary error, the time will be extended through the last day of the sixth calendar month after the month in which the error is rectified but

not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

2. The time limit is extended to the next workday if it falls on a day which is not a Federal workday (e.g., Saturday, Sunday, legal holiday).

When bills are not timely filed they must be denied; however, such bills should be filed and processed.

If error of the SSA or its agents or the patient caused the bill to be filed late, a statement outlining the facts should be attached to the bill.

When the intermediary or SSA determines that the late filing was the patient's fault, the patient will be responsible for the bill; if the facility is at fault in not filing a timely bill, the facility can bill the patient only for the deductible and coinsurance amount.

The intermediary will submit to the SSA for advice any claim in which delay in establishing HI or SMI entitlement or notifying an individual of HI or SMI entitlement prevents the filing of a claim until more than 3 years after the year in which the services were furnished (fourth year after the year, in the case of services furnished in the last quarter of the year).

240.4 Time Limit for Filing Part B Reasonable Charge Claims.--For Medicare payment to be made for a claim for physician and other Part B services reimbursable on a reasonable charge basis (including those services for which the charge is related to cost) the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March 1968.

241. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the patient should sign the request at the time outpatient physical therapy or speech pathology services begin.

In certain circumstances, this is impracticable; for example, when the individual is incompetent or otherwise is in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of start of services, be asked and permitted to sign on his behalf.

242. REFUNDS

In its agreement for participation, the clinic, rehabilitation agency, or public health agency has agreed not to charge any individual or other person (e.g., relatives, other insurance carriers, or welfare) for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and to make provision for the refund (or other required disposition) of any moneys incorrectly collected from the individual or other person on his behalf.

Amounts incorrectly collected and not refunded represent improper charges for covered services under the provisions of section 1866(a)(1) of the Social Security Act, and for an outpatient physical therapy or speech pathology provider to retain these moneys and not make provision for refund (or other required disposition) constitutes a violation of its provider agreement.

A. Moneys incorrectly collected means amounts in excess of allowable charges and deductible and coinsurance amounts, if applicable, paid to an outpatient physical therapy or speech pathology provider by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program.

B. A majority of incorrect collections are made inadvertently and may involve a simple error on the part of the provider in billing a beneficiary. However, there are other situations which lend themselves to the possibility of an incorrect collection being made. For example:

1. In a retroactive entitlement case, where the beneficiary (or other person) paid for covered services and later becomes entitled to have payment made for them under Medicare;

2. Where an intermediary (carrier) has initially denied payment and a subsequent finding is made (e.g., as the result of a reconsideration or hearing decision) that payment for all or part of the same services may be made; and

3. Where the beneficiary or other person has protested a direct charge by a provider and the intermediary determines that the beneficiary is entitled to have program payment made on his behalf for all or part of the same services.

The intermediary will assure that providers refund moneys incorrectly collected. Therefore, in the situations described above (and other similar situations recognized by the intermediary), the intermediary (carrier) will ascertain, on an individual case basis, whether the provider has already received reimbursement for covered services from the individual or other person (e.g., relatives, other insurance carriers, or welfare) before making Medicare payment. If the provider advises, in writing, that it has not been reimbursed by the individual or other person for covered services, payment can be made.

If the provider has already been reimbursed in whole or in part, the intermediary (carrier) will withhold an amount equal to the incorrect collection from amounts otherwise due the provider until it is assured in writing by the provider that a proper disposition of the incorrect collection has been made.

Where the intermediary (carrier) knows that a provider has overcollected deductible and coinsurance amounts for Part B services for outpatient physical therapy or speech pathology services, direct refund will be made by the intermediary (carrier) to the beneficiary.

242.1 Return or Other Disposition of Moneys Incorrectly Collected.-- An outpatient physical therapy or speech pathology provider in possession of any incorrect collection is required to refund or make final disposition of the money in accordance with applicable State law. If refund or final disposition will be delayed for a prolonged period, the provider is required to set aside the money in a separate account until refund or final disposition can be made. Until the provider advises, in writing, that it has properly refunded or disposed of the money or, as necessary, set aside the money, the intermediary will withhold an amount equal to such incorrect collection against amounts otherwise due the provider.

A. Refund.-- Refund is to be made to the beneficiary (or anyother person) from whom the provider collected the moneys. If the beneficiary or other person cannot be located after the provider has made a reasonable effort including an attempt at contact by mail at the last known address, the intermediary will be asked to check SSA's records in an effort to learn the individual's address. If the individual to whom refund is to be made still cannot be located or has died, the provider will make final disposition of the moneys in accordance with the law of the State in which the provider is situated.

B. Moneys Set Aside.-- In some situations refund or final disposition may be delayed for a prolonged period (e.g., where the beneficiary's whereabouts is being developed or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual). When such a delay in making refund or final disposition is encountered, the provider of services will notify the intermediary and will then set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These amounts will be carried on the provider's records in this manner until refund of final disposition, as provided in paragraph A above, can be made.

242.2 Appropriate Time Limits Within Which Provider Must Dispose of Sums Incorrectly Collected.-- Refund or final disposition in accordance with applicable State law of sums incorrectly collected should be accomplished as promptly as possible. In any event, refund, final disposition, or as necessary, setting funds aside in a separate account should be accomplished within a period of 60 days after the provider is notified that an incorrect collection was made.

242.3 Former Participating Outpatient Physical Therapy or Speech Pathology Providers.-- Once an outpatient physical therapy or speech pathology provider has become a praticipating provider, it remains responsible notwithstanding the subsequent termination of its program participation, for the required refund or final dispositon of any moneys incorrectly collected for covered services furnished to Medicare beneficiaries during the effective period of its provider agreement.

Workers' Compensation

245. GENERAL INFORMATION

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation law or plan of the United States or a State. Moreover, if it is determined that any Medicare payment has been made for items or services which can be or could have been paid for under workers' compensation, the Medicare payment constitutes an overpayment.

This exclusion is applicable to the worker's compensation plans of the 50 States, the District of Columbia, Guam, and Puerto Rico. It also applies to the Federal workers' compensation plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung program).

These Federal programs provide workers' compensation protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State workers' compensation programs; e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post-exchanges), and offshore oil field workers.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a workers' compensation law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered workers' compensation acts for purposes of this exclusion.

Workers' Compensation

245. GENERAL

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs; e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post exchanges), and offshore oil field workers. The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of the individual State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

245.1 Definitions.--

A. Workers' Compensation Law or Plan.-- A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

B. Workers' Compensation Agency.--The term "workers' compensation agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.

C. Workers' Compensation Carrier.-- The term "workers' compensation carrier" means any insurance carrier authorized to write WC insurance under the State or Federal law, the State compensation fund where the State administers the WC program, and the beneficiary's employer where the employer is self-insured.

D. Lump-Sum Commutation Settlement.--The beneficiary accepts a lump sum payment which compensates for all future medical expenses and disability benefits related to the work injury or disease.

E. Lump-Sum Compromise Settlement.--A settlement which provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

F. HCFA's Claim.--Is the amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any applicable procurement costs.

245.2 Effect of Payments Under Workers' Compensation Plan.--

A. General.--No Medicare payment may be made if WC has paid an amount:

- o Which equals or exceeds the gross amount payable by Medicare without regard to deductible and coinsurance;
- o Equals or exceeds the provider's charges for Medicare covered services; or
- o Which the provider accepts or is required under the WC law to accept as payment in full.

B. Deductibles.--Payments made under WC cannot be applied toward the Medicare deductibles. Medical expenses do not count toward the Part B deductible if paid for under WC.

C. Spell of Illness.--Where a beneficiary receives inpatient hospital services or extended care services, a spell of illness begins on the first day (not included in a previous spell of illness) on which he receives such services even though the services are paid for by WC.

D. Benefit Utilization.-- In most instances, where an injury or illness is covered under a WC plan, that plan pays all hospital and medical expenses. Where this is the case, services paid for under WC are not counted against the individual's entitlement to 90 days of inpatient hospital services, 60 lifetime reserve days, or 100 days of skilled nursing facility services. Nor will such services count against the 190-day lifetime limitation on inpatient psychiatric hospital services.

245.3 Secondary Medicare Payments.—

A. General.--If WC pays for Medicare covered services (including outpatient services) an amount which is less than your charges and less than the gross amount payable by Medicare, as defined below (without considering the effect of the Medicare deductible or coinsurance or the payment by WC), and you do not accept and are not required, under the WC law, to accept the payment as payment in full, Medicare secondary payments can be made.

B. Amount of Secondary Payments.--The Medicare secondary payment is the gross amount payable by Medicare minus the amount paid by WC for Medicare covered services, minus any applicable deductible or coinsurance amount. The gross amount payable by Medicare means the current Medicare interim reimbursement amount (as defined in §336).

C. Charges Included Non-Work-Related Items or Services.—If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related, secondary Medicare benefits may be paid in accordance with subsection B, to the extent that the services are not covered by any other source which is primary to Medicare. (See §335 for billing procedures.) You are permitted, under WC law, to charge an individual or the individual's insurer for services which are not work related.

You may not charge a beneficiary or any other party for Medicare-covered services, if you have been paid by WC an amount that equals your charges or equals or exceeds the gross amount payable by Medicare as defined in subsection B. This prohibition is based on the terms of your Medicare participation agreements, under which you may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services.

245.4 **Workers' Compensation Cases Involving Liability Claims.**--Most State laws provide that if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, the services do not come under the WC exclusion to the extent of the nonpayment or recovery by WC. However, the services may be excluded under the provision which makes Medicare secondary for services covered under liability insurance. Consider these cases under the policies in §§248ff.

245.5 **Possible Coverage Also Under Auto Medical or No Fault Insurance or Employer Group Health Plan.**--Where services are covered in part by WC and also under automobile medical or no-fault insurance, or there is primary coverage by an EGHP, Medicare would be the residual payer only. (See §§247ff., 249, 250 and IM 251 respectively.)

Accordingly, whenever WC pays in part for provider services and you do not accept and are not obligated to accept such payment as payment in full, assure that a claim is submitted to any other insurer that is primary to Medicare.

If the services are related to an automobile accident, ascertain whether your records show coverage under automobile medical or no-fault insurance. Where your records do not show such coverage, contact the beneficiary to ascertain whether such coverage exists. If there is coverage under automobile medical or no-fault insurance, submit the unpaid portion of the bill to the automobile insurer and follow the instruction in §247.2.

If there is no coverage under automobile medical or no-fault insurance, but another insurer is shown on the bill, and there is indication of primary EGHP coverage under §§249, 250 or IM 251, bill the other insurer for the services not paid for by WC. Follow the instructions in these sections as appropriate, and bill the other insurer because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is an EGHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §§247ff.) and there is no indication of primary EGHP coverage under §§249 or 250, bill Medicare for secondary Medicare payments determined in accordance with §245.3.

In all instances in which Medicare makes secondary payments, show the appropriate value code as defined in §360 (items 46 - 49).

245.6 Contested Workers' Compensation Claims.--

A. General.--An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise between the parties with the approval of the WC agency.

B. Conditional Medicare Payments.--Conditional Medicare benefits may be paid while a WC claim is being contested. There frequently is a long delay between the occurrence of an injury or illness and the decision by the State WC agency. A denial of Medicare benefits pending the outcome of the appeal would mean that individuals might be required to advance their own funds to pay for expenses which will eventually be borne by either Medicare or by WC. To avoid imposing hardship on Medicare beneficiaries while a decision is being made by the WC agency, conditional Medicare payments may be made pending a final decision on the WC claim.

245.7 Lump-Sum Compromise Settlement.--If a WC agency approves a lump-sum settlement of a case where compensability is contested, the lump-sum settlement is deemed to be a WC payment, even if the settlement agreement stipulates that there is no WC liability.

Medicare does not accept manipulation of any settlement proceedings intended to shift liability to the Medicare program. Where such manipulation is apparent, Medicare denies payment.

If the individual signed a final release of all rights under WC (which precludes the possibility of further WC benefits), medical expenses incurred after the date of the final release are reimbursable under Medicare, insofar as such subsequent medical expenses were not contemplated by and incorporated into the settlement.

Where the settlement specifies that a portion of the settlement is for future medical expenses, Medicare may not pay for those expenses until such time that the beneficiary has submitted bills related to the injury or illness totalling the amount of the lump-sum settlement allocated to medical treatment.

245.8 Lump-Sum Commutation of Future Benefits.--When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the medical condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until such time that the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment.

245.9 Right of Recovery.--All Medicare payments are conditioned on reimbursement to the appropriate Trust Fund, when notice or other information is received that payment with respect to the same items or services has also been made, or could be made, under a WC law or plan of the United States or a State.

Section 1862(b)(1) as amended, now expressly provides that:

o The Government may recover directly from employers and WC carriers, Medicare benefits it paid for services that are reimbursable under WC. The Government may recover from WC whether or not the beneficiary is filing a WC claim with respect to the injuries.

o The Government may recover benefits it paid for services that are covered under WC, from any entity that has been paid by an employer or by a WC carrier.

o The Government is subrogated to the right of any entity to receive payment from an employer or a WC carrier. "Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the Government is given whatever rights the beneficiary or any other entity had against the employer and the WC carrier to the extent that Medicare has made payments to or on behalf of the beneficiary.

o The Government may join or intervene in any WC claim where the compensability of the injury is at issue.

245.10 Private Right of Action.--Section 1862(b)(5) provides that where an individual is awarded WC benefits but the WC carrier does not pay primary benefits, the Medicare beneficiary has a right to take legal action against the WC carrier and can collect double the amount that would have been payable had primary benefits been paid. If such litigation is successful, the Medicare program can recover the amount paid by Medicare.

245.11 Handling of Cases Involving Work-Related Conditions.--

A. General.--Information you supply is the primary means of alerting intermediaries to actual or potential WC coverage in specific cases involving work-related conditions. A condition would be considered to be work related if it resulted from (1) an accident that occurred on the job, or (2) from an occupational disease. If any of the following conditions apply, annotate items 35-39 of the HCFA-1450 with condition code 02:

o The physician or the patient states that the condition is work related; (See §311 for questions beneficiaries are to answer at time of admission.)

o The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;

- The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis and "black lung" disease in the case of a coal miner) (see §245.18); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic or mercury poisoning;
- The beneficiary previously received WC for the same condition;
- There is indication that a WC claim is pending;
- There is other indication that the condition arose on the job.

B. Responsibility of Provider to Document Cases in Which There Is a Possibility of Workers' Compensation Coverage.--Inquire of the beneficiary whether the condition is work related. Where the patient or his physician indicates that the condition is work related or there is other indication that the condition is work related (see subsection A), ask the patient whether WC is expected to pay for the services.

If the patient denies that WC benefits are payable for a condition which you believe may be covered by WC, attach a supplementary statement to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

245.12 Workers' Compensation Has Paid or Is Expected to Pay.--Where there is indication that WC may pay for the services, bill the WC carrier. If WC pays only a portion of the charges, bill Medicare in the manner described in §335.

245.13 Workers' Compensation Denies Payment.--If the WC claim is denied, determine whether any other Medicare Secondary Payer provisions apply and bill as appropriate. If no other primary payers are available, submit (1) a bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in items 28-32, and (2) a supplementary statement calling attention to the fact that WC has denied payment or annotate item 94, remarks, with the reason for the denial.

245.14 Action By Provider Where Benefits May Be Payable Under Federal Black Lung Program.—The Department of Labor (DOL) pays for certain items and services and for specific drugs relating to the treatment of pneumoconiosis (black lung disease). A list of the common diagnoses relating to black lung disease is located in §245.18. In some instances, DOL covers certain items and services under limited conditions only. In such cases, a Certificate of Medical Necessity (CMN) is required. This DOL form (CM-893) is completed by the prescribing physician and must be approved by DOL before it reimburses for the services or items. Approvals may be given for a specific time only and in such cases it is not necessary to submit a copy of the CMN with each bill during the approved period.

If the CMN is rejected by DOL, then the items or services can be billed to Medicare with a copy of the DOL denial attached. However, if the individual's condition changes and test results confirm this, submit a new CMN to DOL for review. Any items or services billed to DOL are not billed to the Medicare program unless a denial has been received from DOL.

If it appears that a Medicare beneficiary may be entitled to have the services reimbursed by DOL under the Federal Black Lung Program, bill DOL (see §245.21 for DOL's address) for the specific services or durable medical equipment (DME) provided to treat a pulmonary disease or directly related conditions. (See §245.19 for a list of DME that is commonly reimbursable by DOL.) Bill the Medicare program only for services not related to the respiratory condition.

245.15 Medicare Payment.--Medicare may pay for any service that is not related to black lung disease (e.g., treatment of diabetes or fracture). Deny any bill for the coverage of services or drugs needed to treat the black lung conditions.

245.16 Questionable Cases.--If there is a question regarding whether a procedure is related to black lung disease, check with DOL.

245.17 DOL Does Not Pay for All of Services.--If you bill DOL and DOL does not pay for the services in full, bill Medicare as provided in §335, attaching a copy of DOL's denial notice. The denial notice should give the specific reason for nonpayment. If a claim is denied because of your failure to furnish documentation needed by DOL, payment may not be made under Medicare.

245.18 DOL's List of Acceptable Diagnoses.--The following is DOL's "Acceptable Diagnoses List" (ADL) and the ICD-9-CM codes.

DOL may pay for services furnished a black lung beneficiary where the diagnosis is one of the following:

DOL'S ACCEPTABLE DIAGNOSES LIST (ADL)

CODE ICD-9-CM	DISEASE/CONDITION
7867	Abnormal chest sounds
5130	Abscess: Lung and Mediastinum

2762	Acidosis - respiratory (only when due to pulmonary disease)
2763	Alkalosis - respiratory (only when due to pulmonary disease)
5163	Alveolocapillary block - pulmonary
4171	Aneurysm - pulmonary circulation
500	Anthracosilicosis
500	Anthracosis
4939	Asthma - Bronchial, unspecified
4931	Asthma - Intrinsic
5000	Asthma - Miners
5180	Atelectasis
0310	Bacterial disease, pulmonary infection by mycobacterium
4820 thru 4829	Bacterial pneumonia
1160	Blastomycosis (Pulmonary ONLY)
4939	Bronchial asthma
4940	Bronchiectasis
4661	Bronchiolitis - acute
4660	Bronchitis - acute
4900 thru 4919	Bronchitis - chronic

CODE ICD-9-CM	DISEASE/CONDITION
2312	Cancer - Bronchus and Lung
7991	Cardio-respiratory failure unless associated with M.I. (Myocardial infarct) or renal failure
7865	Chest Pain (excludes angina)
7931	Coin lesion (lung)
4280	Congestive heart failure - secondary to pulmonary disease - that is, with pulmonary hypertension, polycythemia or cor pulmonale. EXCLUDED is CHF when associated with: valvular heart disease, ischemic heart disease such as ASCD, ASHD, ASCVD, MI (myocardial infarct) or angina. CHF is not covered when associated with renal failure.
496	COPD (chronic obstructive pulmonary disease) acute exacerbation
4150	Cor pulmonale - acute pulmonary heart disease
483	Eaton agent - pneumonia
4280	Edema - pulmonary - CHF
4151	Embolism - pulmonary, covered if associated with polycythemia; not covered if post-operative other than lung surgery.
5100 thru 5109	Empyema
4920	Emphysema - chronic
4170	Fistula - pulmonary circulation

CODE ICD-9-CM	DISEASE/CONDITION
487	FLU (Influenza)
0391	Fungus - pulmonary infection
7863	Hemoptysis
11505	Histoplasmosis, pneumonia
487	Influenza
7866	Mass in lung
0310	Mycobacterium - pulmonary
1622 thru 1629	Neoplasm - malignant, lung or bronchus
78652	Painful respiration
5110 thru 5119	Pleurisy
481	Pneumococcal pneumonia
4661	Pneumonia - capillary
483	Pneumonia - Eaton agent, Mycoplasma PPLO
4820 thru 4829	Pneumonia - other bacteria
4840 4860	Pneumonia - other disease/other organisms
481	Pneumonia - Pneumococcal
4809	Pneumonia - viral
5120	Pneumothorax, non traumatic

CODE ICD-9-CM	DISEASE/CONDITION
483	PPLO - pneumonia
4160	Pulmonary heart disease
4179	Pulmonary circulation disease
5180	Pulmonary collapse, nontraumatic
4151	Pulmonary embolism
7942	Pulmonary function reduced
7863	Pulmonary hemorrhage
7867	Rales
2762	Respiratory acidosis (due to respiratory condition)
2763	Respiratory alkalosis (due to respiratory condition)
7991	Respiratory arrest
78609	Respiratory distress
7991	Respiratory failure
78609	Respiratory insufficiency
4179	Rupture, pulmonary circulation
7931	Shadow chest x-ray, abnormal
502	Silicosis
78609	Shortness of breath

CODE ICD-9-CM	DISEASE/CONDITION
7864	Sputum, abnormal
4178	Stricture, pulmonary circulation
7861	Stridor
7850	Tachycardia - unspecified (acceptable when no non-covered conditions are listed)
78609	Tachypnea, abnormal breathing
0119	Tuberculosis
7867	Tympany
4809	Viral pneumonia

245.19 Examples Where DOL Requires a Certificate of Medical Necessity.--DOL pays for certain items and services only under limited conditions and provided a Certificate of Medical Necessity (CMN) is submitted. (See §245.14.) For example:

- o Pulmonary rehabilitation therapy such as percussions, postural drainage, heated aerosol, sputum induction, and rehabilitation classes.

- o The following items of Durable Medical Equipment (DME).

Item

Wheelchair, standard
Wheelchair, electric
Wheelchair, special or other

Oxygen, cylinder
Oxygen regulator
Flowmeter
Oxygen regulator, other
Oxygen concentrator
Oxygen concentrator, special or other

Item

O_2 Humidifer
Portable oxygen system, Mada Porta-Pak
Portable oxygen refill
Liquid oxygen set-up, complete with portable system
Liquid oxygen set-up portable system only
Portable oxygen system with flowmeter & humidifier
Portable oxygen system, Erie Traveler, complete
Cannula
Oxygen mask
Stand for tank oxygen
Oxygen cylinder cart
Hand held nebulizer without compressor motor
Hand held nebulizer with compressor motor
Nebulizer, other (Ultra sonic not reimbursable)
Portable manual resuscitator
Aspirator
Aspirator, special or other

Services

Oxygen set-up
Oxygen set-up, follow up
Demurrage on tank oxygen
Maintenance on DME purchase item

245.20 Examples of Services Covered by DOL Where No Certificate of Medical Necessity Is Required.--DOL pays for respiratory therapy that is for treatment of an acute pulmonary episode. Such therapy may consist of the administration of oxygen or nebulization treatments.

However, repeated aerosol therapy over an extended period of time is not reimbursed by DOL because in such cases the individual should be furnished a nebulizer for daily use.

245.21 DOL's Address.--The address for sending bills to DOL is:

Federal Black Lung Program
P.O. Box 740
Lanham, MD 20706

Bill DOL for oxygen, DME and drugs on form HCFA-1500 using CPT-4 codes.

If you have any questions regarding billing to DOL, call toll-free:

Maryland -- 1-800-492-5737
Nationally -- 1-800-638-7072.

245.22 Conditional Medicare Payment in Contested Workers' Compensation Cases.--Where WC benefits have been claimed for items or services otherwise covered by Medicare, but the WC claim is contested (i.e. where an employee is appealing a decision by the employer, WC carrier or agency denying WC benefits; or an employer or WC carrier is appealing a decision of the WC agency awarding such benefits), conditional Medicare payment may be made for such items or services under the conditions specified below, pending a final decision on the WC claim.

NOTE: If the injury resulted from an automobile accident and/or there is indication of primary coverage under an employer group health plan, bill the automobile insurer and/or employer plan as appropriate, in accordance with the instructions in §247ff., §249, §250 or SIM 251 before requesting conditional payments. (See §245.5.)

245.23 Effect of Lump-Sum Compromise Settlement and Final Release.--Where a lump-sum settlement and final release of a WC claim is entered into and approved by the WC board or agency, payment may be made under Medicare for expenses incurred for covered services to the extent that such expenses cannot reasonably be deemed to have been reimbursed under the settlement. Therefore, where under the State law, the signing of a final release of all rights under the WC claim precludes the possibility of further WC benefits, medical expenses incurred thereafter are reimbursable under the Medicare program, insofar as such subsequent medical expenses were not contemplated by and incorporated into the settlement.

245.24 Apportionment of Lump-Sum Compromise Settlement of Contested Workers' Compensation Claim.--After conditional payments have been made under §245.6B, a contested WC claim may be settled by means of a compromise lump-sum award. Where a lump-sum compromise settlement allocates a portion of the settlement as payment for medical and hospital expense and also gives reasonable recognition to the income replacement objective of the WC law, the settlement may be accepted as a basis for applying the WC exclusion.

o Where the settlement specifies the items of medical and hospital expense which it is intended to cover, Medicare payments may not be made for the expenses specified in the settlement as covered by the WC award.

o Where the award does not identify which items of medical or hospital expense it is intended to cover, the amount of the award allocated to medical and hospital expense incurred up to the date of the award is applied at the prevailing WC schedule in that jurisdiction first to those medical and hospital services covered by WC but not covered by Medicare, and second to expenses covered by WC and by Part B (excluding provider services).

Any remainder of the WC settlement is treated as payment for provider services. The amount to be recovered from the beneficiary for provider services will be any amount Medicare paid in excess of the amount that it should have paid as secondary payer.

o Where a lump-sum WC settlement covers both medical care and disability benefits but does not apportion the sum granted between medical and hospital expenses and income replacement, send all information to the intermediary, which calculates the amount of the WC award deemed to be payment of medical and hospital expenses and notifies you of this amount.

245.25 Overpayment Due to Workers' Compensation Payments.--When you learn that you will receive a WC payment after you have been reimbursed by Medicare for the same items and services, prepare a corrected bill. The noncovered charges should include the charges for items and services paid for under WC. The overpayments may be repaid by direct refund or adjustment of program payments due you.

247 SERVICES REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO FAULT INSURANCE

Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under automobile medical or no fault insurance (including a self-insured plan). Medicare is secondary to automobile medical or no fault insurance even if State law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis in accordance with §247.2B, they are subject to recovery.

If services are covered under automobile medical or no fault insurance, the automobile insurer must be billed first. If the automobile insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted in accordance with §247.3C to supplement the amount paid by the automobile insurer. Medicare can pay for services related to an automobile accident, if benefits are not currently available under the individual's automobile medical or no fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on nonmedical items such as lost wages.

The question to be asked in each case involving automobile related medical expenses is whether automobile medical or no fault benefits can be paid for these particular services. If so, the automobile insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her automobile insurance benefits to pay for future services. Since automobile insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

In accordance with a "grace period" granted in the regulations, there will be no attempt to recover Medicare payments if an automobile insurance payment was received by the beneficiary before June 6, 1983. The "grace period" does not apply to insurance payments to providers of services. However, no effort will be made to recover if you turned the insurance payment over to the beneficiary before that date.

If there is an indication that the individual has filed, or intends to file, a liability claim against a party that allegedly caused an injury, follow instructions in §247.2B.

A. Effective Dates.—The general rule is that these provisions are effective with respect to services related to injuries which occurred on or after December 5, 1980. If benefits might be payable under automobile medical or no fault insurance but, for whatever reason, such benefits have not been paid, the provisions are effective with respect to services furnished on or after June 6, 1983.

Thus, for example, where an automobile insurer refuses to pay primary benefits for services furnished before June 6, 1983, because a State law or private contract of insurance stipulated that Medicare is primary, Medicare primary benefits may be paid. In the case of services furnished on or after June 6, 1983, Medicare pays only secondary benefits notwithstanding such a provision in the State law or private contract.

The specific application of the general rule follows:

1. Automobile Payment Made

   a. Denial of Medicare payment; or

   b. Recovery of Medicare payment, but not if the beneficiary received the automobile payment before June 6, 1983.

2. Automobile Payment Not Made — Automobile Medical or No Fault Insurance Coverage Exists

   a. Medicare primary payment for services furnished before June 6, 1983.

   b. Denial or recovery of Medicare primary payment for services furnished on or after June 6, 1983. (Conditional primary Medicare payments permissible if automobile insurer contests liability.)

B. Effect on Deductibles.—Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under automobile medical or no fault insurance are not counted toward the Part B deductible amount.

247.1 Definitions.—

A. Automobile.—Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Automobile Medical or No Fault Insurance.—Insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for causing the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

C. Liability Insurance.—Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply where the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

D. Self-Insured Plan.—A plan under which an entity (or an individual) is authorized by State law to carry its own risk instead of insuring itself with a carrier.

E. Uninsured Motorist Insurance.—Liability insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

247.2 Provider Actions.—

A. Information Obtained from Patient or Representative At Start of Care.—In order to ascertain whether to bill an automobile insurer, ask Medicare patients, or the patient's representative, at the start of care if the services are for the treatment of an injury or illness which resulted from an automobile or other accident or for which they hold another party responsible. For automobile accidents, obtain the name, address and policy number of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses that resulted from the accident.

B. Billing Where Services Are Related to an Automobile Accident.—In the following circumstances, complete the billing form in accordance with the instructions in §332:

1. If you learn that an automobile medical or no fault insurance company may pay for otherwise covered services, bill the automobile insurance company as primary insurer. You may bill Medicare for secondary benefits per §247.3C if the automobile insurer does not pay in full for the services.

2. If the services are related to an automobile accident and an automobile insurer has been billed but does not make payment because, for example, the individual's automobile coverage expired, or the automobile medical or no fault claim is contested by the insurer, or for any other reason there will be substantial delay in resolving the claim, bill Medicare. Unless you submit a satisfactory explanation that full or partial payment cannot be made under an automobile insurance policy, the Medicare claim will be returned and you will be advised to bill the automobile insurer. If you bill Medicare and later receive payment from the automobile medical or no fault insurer, refund the Medicare payment by submitting a corrected bill.

Refusal by an individual to file a claim with an automobile insurer or to cooperate in your filing such a claim is not a basis for claiming a conditional Medicare payment.

3. If the individual files a claim against a third party for injuries suffered in an automobile accident, you may bill Medicare for otherwise covered expenses to the extent that payment has not or cannot be made by an automobile or no fault insurer or has not been made by a liability insurer. For example, an individual incurs $20,000 in medical expenses due to an automobile accident. The individual receives $5,000 in no fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the no fault insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

C. Request From Insurance Company or Attorney.—Notify the intermediary promptly if you receive from an attorney or insurance company a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

D. You Receive Duplicate Payments.—Refund the excess Medicare payment by submitting a corrected bill, if you receive duplicate payments from an automobile insurer and from Medicare, regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

E. You Learn You Should Have Billed Automobile Medical or No Fault Insurance Instead of Medicare.--If, after you received a primary Medicare payment, you learn that the items or services could be paid for under automobile medical or no fault insurance, notify your intermediary. The intermediary will seek refund of Medicare's payment from the automobile insurer and prepare an adjustment bill, if required.

247.3 Automobile Medical or No Fault Insurance Does Not Pay in Full.—

A. Insurance Pays Service Benefits.—If the amount of payment for particular services under automobile medical or no fault insurance is less than your charges but is deemed payment in full under State law, Medicare benefits are not payable. The insurance payment constitutes a service benefit; i.e., the payment constitutes full discharge of the patient's liability to the provider.

B. Other Situations.—In other cases, automobile medical or no fault insurance may not pay your charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage, or because of some other coverage limit, deductible or coinsurance applicable to all policyholders. (See §247.4.)

You are not permitted to charge a beneficiary or any other party for Medicare covered services, if you have been paid by an automobile insurer an amount that equals or exceeds the gross amount payable by Medicare, as defined in paragraph C below. This prohibition is based on the terms of your Medicare participation agreement, under which you may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services.

C. Secondary Medicare Payments.—If an automobile insurer pays for Medicare covered services an amount which is less than your charges and the current Medicare interim reimbursement amount (without considering the effect of the Medicare deductible or coinsurance or the payment by the automobile insurer), and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made. In general, the Medicare secondary payment will be the current Medicare interim reimbursement amount, minus the amount paid by the automobile insurer for Medicare covered services, minus any applicable deductible or coinsurance amount. The current Medicare interim reimbursement amount is defined in §335.

For detailed billing and reimbursement instructions, refer to §332.

247.4 Automobile Medical or No Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy.-- In a number of States automobile insurers may reduce automobile medical or no fault insurance benefits by deductible or coinsurance amounts. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such an automobile insurance contract. The usual Medicare deductibles and coinsurance are applied in calculating the Medicare secondary payment. Therefore, if an automobile medical or no fault insurer has been billed and has made no payment or only a partial payment (e.g., the automobile insurance deductible has been bridged) because of a deductible or coinsurance, you may bill Medicare and should complete the billing form in accordance with §332.

EXAMPLE 1: Beneficiary receives outpatient physical therapy services covered by no fault automobile insurance. Total charges are $200. The automobile insurer is billed but makes no payment because of $1000 deductible in policy. Bill Medicare for $200 in accordance with §332.

EXAMPLE 2: Beneficiary's care is covered by no fault automobile insurance, which allows your full charges but reduces payment by $800 remaining unmet in $1000 deductible provision in policy. You may bill Medicare for $800 in accordance with §332.

EXAMPLE 3: Beneficiary's care paid for by no fault automobile insurance except for $1000 deductible, for which you may bill Medicare in accordance with §332.

Liability Insurance

248 SERVICES REIMBURSABLE UNDER LIABILITY INSURANCE

248.1 General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under a liability insurance policy or plan (including a self-insured plan). (If Medicare payments have been made but should not have been because the services are excluded under this provision, or if the payments were made on a conditional basis in accordance with §248.3B, they are subject to recovery.)

If a Medicare beneficiary has filed or plans to file a liability claim against a party that allegedly caused an injury or illness, Medicare will initially pay for services related to that injury or illness (if they are otherwise covered). Since liability claims are usually not settled or adjudicated until after protracted negotiations and possible litigation, payment by a liability insurer cannot reasonably be expected merely because a beneficiary has filed a liability claim. However, Medicare payment is conditioned on recovery from the beneficiary, if the beneficiary later receives a judgment on, or settlement of, the claim which results in payment by a liability insurer or a self-insured party.

A. Effective Dates.--The general rule is that these provisions are effective with respect to services related to injuries which occurred on or after December 5, 1980. (In the case of a liability claim based on illness rather than trauma, these provisions are effective with respect to services furnished on or after December 5, 1980, unless the liability award or settlement specifies that the illness was caused solely by an occurrence or activity that took place before December 5, 1980.) The specific application of the general rule where a liability (including automobile liability) insurance claim is filed is as follows:

1. Liability Payment Made

(a) Denial of Medicare payment; or

(b) Recovery of Medicare payment for services rendered up to the date of the liability payment, but not if the beneficiary received the liability payment before June 6, 1983.

2. Liability Payment Not Made

(a) Conditional Medicare payment, and

(b) Recovery of Medicare payment, but not if the beneficiary receives liability payment before June 6, 1983.

B. Effect on Deductibles .—Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under liability insurance are not counted toward the applicable Part B deductible amounts.

248.2 Definitions.—

A. Automobile.—Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Liability Insurance.—Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply where the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

C. Self-Insured Plan.—A plan under which an entity (or an individual) is authorized by State law to carry its own risk instead of insuring itself with a carrier.

D. Uninsured Motorist Insurance.—Insurance under which the policy holder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

E. Accident.--Any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable.

248.3 Provider Actions.--

A. Information Obtained from Patient or Representative At Time of Start of Care, or From Hospital or SNF.--Ask Medicare patients, or the patient's representative, at the time of start of care, if the services are for treatment of an injury or illness which resulted from an automobile or other accident or for which he or she otherwise holds another party responsible. If the services are for treatment of an accident, ask the beneficiary for the name and address of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses which resulted from the accident. Some or all of this information may be available from the hospital or SNF where a beneficiary inpatient stay preceded OPT provider services.

B. Billing Where Services Are Related to an Automobile Accident.--In the following circumstances , annotate the billing form in accordance with the applicable instructions in §332:

1. If you have evidence establishing that the services are not covered under the individual's automobile medical or no fault insurance, e.g., the individual's automobile insurance coverage expired, bill Medicare. The intermediary may contact the beneficiary about possible liability coverage.

2. If expenses are covered under automobile medical or no fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, bill Medicare for otherwise covered expenses not covered by the automobile medical or no fault insurance and not paid for by a liability insurer. For example, an individual incurs $20,000 in medical expenses due to an automobile accident. The individual receives $5,000 in reimbursement from an automobile insurer and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the automobile insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

C. Billing Where Services Are Related to an Accident Other Than an Automobile Accident.--If you learn that otherwise covered services are related to an accident that was not an automobile accident, bill Medicare to the extent that the services have not been paid for by a liability insurer and annotate the bill in accordance with §332. The intermediary may contact the beneficiary about possible liability coverage. (If a liability insurer is willing to pay for the services, you may bill the insurer instead of Medicare.)

D. Request From Insurance Company or Attorney.--Notify the intermediary promptly if you receive from an attorney or insurance company a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

E. Provider Receives Duplicate Payment.—Refund the Medicare payment by submitting an adjustment bill if you receive payment for the same services from the beneficiary or an automobile or liability insurer and from Medicare, regardless of which payment you received first and even if you have already refunded the automobile insurance payment to the insurer or to the beneficiary.

If you have received payment from Medicare, and the beneficiary received an automobile or liability insurance payment through you or directly from the insurer, the beneficiary is required to refund the Medicare payment up to the amount of the insurance payment, but not if he or she received the insurance payment before June 6, 1983.

248.4 Automobile or Liability Insurer Pays in Part for Services.—In some cases, automobile medical or no fault insurance will not pay an OPT provider's estimated cost in full because medical expenses exceed the dollar limit of the coverage or because of some other coverage limit. Although Medicare will ordinarily pay first when liability insurance is involved, it may also happen that a liability insurer will pay first and will not pay the estimated costs in full. The intermediary determines the amount of Medicare payment to the OPT provider in such cases. Medicare will pay the difference between the current Medicare interim reimbursement amount for visits or services under §332 (unreduced by any coinsurance or deductible, where applicable (e.g., durable medical equipment, ambulance service billed on HCFA-1450)) and the automobile or liability insurer's payment, subject to any applicable Medicare deductible or coinsurance.

EXAMPLE: An individual received outpatient physical therapy services for which the total charges were $160 and for which an automobile insurer paid $70. The current Medicare interim reimbursement amount for the same services in the absence of the insurance payment would have been $140. Medicare interim reimbursement minus the automobile insurer's payment is $70 ($140 - $70). Medicare pays that amount on an interim basis less applicable deductible and coinsurance.

249 LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

249.1 General.--Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals entitled to benefits solely on the basis of end stage renal disease (ESRD) , during a period of up to 12 months, which is defined in §§249.4 and 249.5. Medicare is secondary during this period even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare's, or otherwise excludes or limits its payments to Medicare beneficiaries.

Under this provision, outpatient physical therapy (OPT) providers must bill the EGHP first for services rendered on or after January 21, 1988. Medicare secondary benefits are payable in accordance with §249.10 if:

o the plan payment is less than your charges for Medicare covered services,

o the plan payment is less than the gross amount payable by Medicare, and

o you do not accept, and are not obligated to accept, the EGHP payment as payment in full.

This provision applies to all Medicare covered items and services furnished to beneficiaries who are in a 12-month period, including services for non-ESRD treatment. Consider the possible application of this limitation when processing claims for items or services furnished to ESRD beneficiaries who are in their first year of entitlement.

NOTE: These instructions do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

249.2 Definitions.--

A. Employer.--The term "employer" means, not only individuals and organizations engaged in a trade or business, but organizations exempt from income tax, such as religious, charitable, and educational institutions as well as the governments of the United States, the States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands and the District of Columbia, including their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision the term "employer" is defined without regard to the number of employees.

B. Employer Group Health Plan or Employer Plan. --These terms mean any health plan that is of, or contributed to by, an employer; and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, and/or their families. It includes the Federal Employees Health Benefits program but not the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). "Employee pay all" plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition of EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

C. Secondary— The term "secondary," when used with respect to Medicare payment, means that Medicare is the residual payer to all employer group health plans under which the Medicare beneficiary is covered and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation exclusion (§245) and no fault and liability insurance provisions (§§247 and 248) in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP. (See §249.9C.)

D. Coordination Period.—The term "coordination period" means a period of up to 12 months determined in accordance with §§249.4 and 249.5 during which Medicare benefits are secondary to benefits payable under employer group health plans.

249.3 Retroactive Application.—If the intermediary notifies you, or you learn from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, take the following actions:

o ascertain whether there is EGHP coverage and if so, the name and address of the EGHP , if that information is not annotated on the claim,

o check your records and ascertain whether Medicare paid primary benefits for other services rendered during a coordination period for which an EGHP may be primary,

o notify the intermediary of the results of your development efforts.

This information is necessary for Medicare to determine its proper payment. If the employer plan pays or has already paid you for all or part of the services, submit a corrected bill to the intermediary along with the employer plan's explanation of benefits (EOB). The intermediary will recoup from you the amount of Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

249.4 Determining the Months During Which Medicare May Be Secondary Payer.--Medicare is secondary to EGHPs for items and services furnished during a period of up to 12 consecutive months which begins with the earlier of:

o the month in which a regular course of renal dialysis is initiated, or

o in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

NOTE: In the extremely rare case of an untimely application by an individual who receives a transplant, the 12-month period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information in file that the transplant occurred before the first actual month of entitlement. If further development is required contact the Social Security office.

When the 12-month period begins before the month the individual becomes entitled to Medicare, Medicare pays secondary benefits for the portion of the period during which the individual is entitled to Medicare benefits. This is the coordination period. (See § 249.2D.) Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare is usually the secondary payer for the first 9 months of an individual's entitlement. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 12 months of the individual's entitlement.

The following examples illustrate how to determine the number of months in which Medicare pays secondary benefits for various situations in which benefits are payable by an EGHP:

(1) Individual Became Entitled to Medicare After a Waiting Period.--Janice started a regular course of dialysis in October 1986. The 12-month period begins in October 1986 (the month in which Janice started a regular course of dialysis) and the waiting period consists of October, November and December 1986. Medicare is secondary payer from January through September 1987.

Peter started a regular course of dialysis in January 1987 and was hospitalized and received a kidney transplant in March 1987. The 12-month period begins with January 1987. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1987. Medicare is secondary payer from March through December 1987.

(2) Individual Became Entitled to Medicare Without a Waiting Period.--In October 1987, John began a regular course of dialysis. In December 1987, he began a course of self-dialysis training. Since the self-dialysis training course was initiated during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1987, the first month of dialysis. In this situation, the first month of entitlement coincides with the beginning of the 12-month period. Thus, the coordination period extends from October 1987 through September 1988. Medicare is secondary payer during this period.

249.5 Effect of Changed Basis for Medicare Entitlement.--If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective.

249.6 Subsequent Periods of ESRD Entitlement.--If an individual has more than one period of entitlement based solely on ESRD, a coordination period will be determined for each period of entitlement in accordance with §§ 249.4 and 249.5.

249.7 Identification of Cases in Which Medicare May Be Secondary to Employer Group Health Plans.--Investigate cases in which information available to you (e.g., the beneficiary's Medicare card) indicates that the beneficiary is entitled to Medicare based on ESRD for 1 year or less at the time the services were rendered to ascertain whether the services were rendered during the 12-month period described in §§249.4 and 249.5. Determine whether the services were rendered in the 12-month period by checking your own records or, if the potential Medicare payment is $50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 12-month period, ask the beneficiary if he/she is insured under any health insurance plan which provides coverage through the employer or through a union. If the response is yes, ask for the name and address of the plan and the beneficiary's identification number.

If the information you obtain does not indicate EGHP coverage but Medicare was the secondary payer on a previous claim based on ESRD, verify the absence of EGHP coverage by inquiring of the beneficiary or the beneficiary's representative. If you verify the absence of EGHP coverage, annotate the bill to that effect (e.g., EGHP coverage lapsed, benefits exhausted). If the information you obtain indicates that EGHP coverage exists, obtain the information cited above from the beneficiary or the beneficiary's representative.

249.9 Billing.--

A. General.--If you determine, based on your development, that Medicare may be secondary to an employer plan, you must bill the EGHP for primary benefits.

B. Billing Medicare for Primary Benefits.--Bill Medicare for primary benefits only if the services were not rendered during a coordination period, or if the EGHP denies a claim because the beneficiary is not entitled to any benefits under the plan, or benefits under the plan are exhausted for the particular services, or the services are not covered by the EGHP.

If you believe that an EGHP may be primary payer, e.g., based on information in your records, ascertain whether primary EGHP benefits are payable, and if so, bill the EGHP for primary benefits. If an EGHP has denied your claim for primary benefits, annotate item 94 "Remarks" of the Medicare claim form with the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 28 - 32. No attachment is needed. See §333. (Refer to §320ff if you are a participating clinic that bills a carrier rather than an intermediary.) However, do not bill Medicare if the reason for the EGHP denial is that the EGHP offers only secondary coverage of services covered by Medicare. Medicare primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage.

C. Billing Medicare for Secondary Benefits.--If an EGHP payment for Medicare covered services is less than your charges and the gross amount payable by Medicare (as defined in §249.10) in the absence of EGHP payment, and you do not accept and are not obligated to accept the plan payment as payment in full, secondary Medicare benefits may be payable on the claim in accordance with §249.10. Prepare the bill in accordance with §333.

There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under his own EGHP as well as under the EGHP of his spouse or under automobile insurance. In such cases, the other primary payers will customarily coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

D. Intermediary Recovery of Primary Benefits.--If primary Medicare benefits are paid to you and the intermediary learns that an EGHP should have paid primary benefits for the items and services, the intermediary either recovers directly from the EGHP or from you. When recovering from you, the intermediary instructs you to file a claim with the EGHP for primary benefits, and upon receipt of the EGHP payment, to refund to Medicare the amount Medicare paid less the amount received from the EGHP. After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary follows up with you in 45 days to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary recovers the Medicare primary payment from you, except where the reason you do not file a claim with the EGHP is because the beneficiary declines to sign the claims form. In that case, the intermediary recovers the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability. When you receive an EGHP refund, credit amounts paid by the EGHP toward the deductible and coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. You may retain any excess EGHP payment over the gross amount payable by Medicare. (See §249.11)

If duplicate payment was or will be made to you, i.e., you received or expect to receive both primary EGHP payments and primary Medicare benefits, the intermediary recovers from you the Medicare overpayment which is the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer. If Medicare paid you and the EGHP paid the beneficiary, the beneficiary is liable.

If the intermediary has not received an adjustment bill within 120 days of notifying you to file a claim with the EGHP, the intermediary follows up to determine the status of the claim. If the EGHP has denied the claim for a reason the intermediary would find acceptable had the intermediary requested payment from the EGHP directly, the recovery action may be cancelled. If the EGHP has denied the claim for any other reason, or has not responded to your claim, the intermediary attempts to recover from the EGHP. Advise the intermediary immediately if you receive payment from the EGHP.

NOTE: OPT participating clinics are reimbursed by carriers. Carriers recover Medicare payments in accordance with procedures prescribed in the Medicare Carriers Manual.

E. Recovery When a State Medicaid Agency Has Also Requested a Refund.--Where both Medicare and Medicaid have paid you benefits and you recover an amount from an EGHP, you are obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim do you have the right to reimburse Medicaid or any other entity.

249.10 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays In Part for Visits and Services.

A. General.--If an EGHP payment for Medicare covered services is less than the your charges for those services and less than the gross amount payable by Medicare (as defined below), and you do not accept and are not obligated to accept the payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment will be the lower of:

- the gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services, or

- the gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is the current Medicare interim reimbursement amount (as defined in §336) for services reimbursed on a reasonable cost basis without regard to the effect of the Medicare deductible or coinsurance or the payment by the EGHP.

For detailed billing and reimbursement instructions, refer to §333.

249.11 Employer Group Health Plan Pays in Full.--If an employer plan payment for Medicare covered services equals or exceeds your charges or the gross amount payable by Medicare for the services in the absence of employer plan coverage, or if you accept or are obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the gross amount payable by Medicare will not be subtracted from your Medicare reimbursement. When appropriate, submit a no payment bill in accordance with §333.

249.13 Effect of EGHP Payments On Deductible and Coinsurance.--Expenses that would be applied to a beneficiary's Part B cash deductible if Medicare were primary payer, are credited to the deductible even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to an OPT provider will be applied to satisfy a beneficiary's obligation to pay a Part B coinsurance amount. However, EGHP payments will be credited to the deductible before being used to satisfy the coinsurance. (See §333.)

249.14 Limitation on Right of an Outpatient Physical Therapy Provider to Charge a Beneficiary.--An OPT provider that receives direct payment from the Medicare program may not charge a beneficiary or any other party, other than an insurer that is primary under §1862(b) of the Act, for Medicare covered services, if the OPT provider has been or could be paid by an employer plan at least an amount equal to any applicable deductible or coinsurance amount. This limitation applies to situations where an insurer is primary under §1862(b) but offers only secondary benefits.

EXAMPLE: Services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. An EGHP paid $85 for the Medicare covered services. The current Medicare interim reimbursement amount (without regard to Medicare deductible and coinsurance amounts) for these services at 90 percent of charges would be $81. Medicare will make no payment since the EGHP payment was greater than Medicare's interim reimbursement amount of $81 would have been. The OPT provider may not charge the beneficiary for the $5 difference between its charges and the EGHP payment since the beneficiary's obligation ($78 for the Medicare deductible and coinsurance*) was met by the EGHP payment.

*The coinsurance is calculated as follows:

$90 charges minus $75 deductible = $15 X 20 percent = $3 coinsurance.
The beneficiary's obligation of $78 is met by the EGHP payment of $85.

249.15 EGHP Erroneously Pays Primary Benefits.--If you determine that an EGHP has inappropriately paid primary benefits, bill Medicare as primary payer and refund to the EGHP the amount it paid, except for an amount equivalent to Medicare deductible and coinsurance amounts, and charges for noncovered services.

249.16 Claimant's Right to Take Legal Action Against an EGHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, an EGHP that fails to pay primary benefits for services covered by the EGHP where required to do so under §1862(b) of the Act.

Limitation on Payment for Services to Employed Aged Beneficiaries and Spouses

250. LIMITATIONS ON PAYMENT FOR SERVICES TO THE EMPLOYED AGED AND THE AGED SPOUSES OF EMPLOYEES WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS.

250.1 General.--Medicare benefits are secondary to benefits payable under EGHPs for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. For items and services furnished from January 1, 1985 - April 30, 1986, Medicare was secondary payer for employed individuals age 65 - 69 and spouses age 65 - 69 of employed individuals of any age through 69. For items and services furnished from January 1, 1983 through December 31, 1984 Medicare was secondary payer for employed individuals age 65 - 69 and their spouses age 65 - 69. Section 250.3 further defines the individuals subject to this limitation on payment. If primary Medicare benefits have been paid for services furnished on or after January 1, 1983 to an individual who meets the criteria in §250.3, the intermediary will recover the Medicare overpayment and instruct you to take action in accordance with §250.13. Billing instructions are in §334.

In general, where an individual meets the criteria in §250.3, bill the EGHP first and, if (1) the plan payment is less than your charges for Medicare covered services, (2) the plan payment is less than the gross amount payable by Medicare as defined in §250.11, and (3) you are not obligated to accept the EGHP payment as payment in full, Medicare secondary benefits may be payable in accordance with §250.11.

The Age Discrimination in Employment Act which is administered by the Equal Employment Opportunity Commission requires employers (as defined below) to offer to their age 65 or over employees and to the age 65 or over spouses of employees of any age, the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. From January 1, 1985 through April 30, 1986, employers were required to furnish such coverage to their age 65 - 69 employees and to the age 65 -69 spouses of employees of any age through age 69. From January 1, 1983 through December 31, 1984 employers were required to offer primary EGHP coverage to their employees age 65 - 69 and to their spouses age 65 - 69. Medicare beneficiaries are free to reject the employer coverage, in which case they retain Medicare as the primary coverage. Employers cannot offer such employees or their spouses coverage on a supplemental basis of services covered by Medicare.

Where an EGHP pays benefits as primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §250.11 to supplement the amount paid by the EGHP for Medicare covered services. Medicare will be the primary payer where an individual has not accepted the primary coverage offered by the employer. If an EGHP denies payment for particular services because they are not covered by the plan, primary Medicare benefits may be paid for them if covered by Medicare.

An EGHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on the Medicare intermediary. Medicare will continue to evaluate claims under existing guidelines derived from the law and regulations to assure that services are in fact covered by the program regardless of employer plan involvement.

250.2 Definitions.—

A. Employer.—The term "employer" as used in these instructions means not only individuals and organizations engaged in a trade or business, but also embraces organizations exempt from income tax, such as religious, charitable, and educational institutions. Included are the governments of the United States, the States, the Territories, the Virgin Islands, Guam, Puerto Rico and the District of Columbia. Only employers with 20 or more employees are required to offer primary coverage to their age 65 or over employees and the age 65 or over spouses of employees. (This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of twenty or more calendar weeks in the current or preceding year.)

Assume for purposes of the requirement that EGHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer allegation that the 20-employee requirement is not met or a multiemployer plan's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payer.

B. Employer Group Health Plan or Employer Plan (EGHP)—These terms mean any health plan that is of, or contributed to by, an employer of 20 or more employees and which provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. This includes a multiemployer group health plan that has at least one employer with 20 or more employees. These plans may identify members who are employees of employers with fewer than 20 employees. Such members and their spouses are considered not to meet the conditions in §250.2.

The Federal Employees Health Benefits program meets this definition of an EGHP for this purpose, but not the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Employee pay-all plans, i.e., group health plans under the auspices of an employer which do not receive any contribution from the employer also meet the definition of EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employee's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare.

C. Secondary.—For purposes of this instruction, the term "secondary" when used with respect to Medicare payment, means that Medicare is the residual payer to all EGHPs under which the Medicare beneficiary is covered by reason of current employment and will not pay for any expenses that are reimbursable by any such plan or plans. The workers' compensation exclusion (§245) and automobile and liability insurance provisions (§§247 and 248) must also be taken into consideration in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP.

D. Age 65 through 69.—Means a period beginning with the first day of the month in which an individual attains age 65 and ending with:

1. For services furnished on or after July 18, 1984, the last day of the month before the month the individual attains age 70.

2. For services furnished before July 18, 1984, the last day of the month in which the individual attains age 70.

An individual attains a particular age on the day preceding his or her birthday.

250.3 Individuals Subject to Limitation on Payment .--Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

A. For services on or after May 1, 1986, is age 65 or over

or

For services before May 1, 1986, is age 65 through 69, and

B. Is entitled to Part A (hospital insurance) of Medicare on the basis of the individual's own social security earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and

C. Is either

1. Employed (an employee or self-employed individual) and covered by reason of that employment by an EGHP; or

2. The spouse of an employed person, covered by an EGHP by reason of that person's employment, and the employed person is:

a. For services on or after May 1, 1986, any age; or

b. For services on or after January 1, 1985 through April 30, 1986, any age through 69; or

c. For services before January 1, 1985, age 65 - 69.

NOTE: A person receiving disability payments from an employer will be considered employed if the disability payments are subject to taxes under the Federal Insurance Contributions Act (FICA) except if the individual was determined to be disabled by the Social Security Administration for the month before the month the individual attained age 65. Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

250.4 Individuals Not Subject to the Limitation on Payment.—Medicare is not secondary payer for:

A. Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement may be on the basis of age 65. (See §249 for secondary Medicare payment instructions where an ESRD beneficiary under age 65 has employer group health plan coverage.)

B. Individuals who are enrolled in Part B only.

C. Individuals enrolled in Part A on the basis of a monthly premium.

D. Anyone who is under age 65 and prior to May 1, 1986, is over age 69.

E. Individuals covered by a health plan purchased by the individual privately, i.e., not as a member of a group.

F. Members of EGHP's of employers of fewer than 20 employees.

G. Members of multiemployer plans who have been identified as employees of employers with fewer than 20 employees.

H. Retired beneficiaries (other than spouses of employed individuals) who are covered by EGHPs as a result of past employment and do not have EGHP coverage as the result of current employment.

250.5 Identification of Individuals Subject to This Limitation on Payment.—In order to ascertain whether to bill an employer plan as primary payer, ask all Medicare beneficiaries age 65 or over if he/she is employed and covered by an EGHP. Also inquire as to whether the beneficiary's spouse is employed and age 65 or over and the beneficiary covered under the group health plan of the spouse's employer. If the response is yes to either question, ask the beneficiary for the name and address of the EGHP and the beneficiary's identification number.

If based on the information obtained in response to the questions above the criteria in §250.3 appear to be met, bill the employer plan first. (See §250.7.) If Medicare is determined to be the primary payer, annotate the Medicare billing form to that effect.

250.6 Identification of Prior Claims that May Involve Employer Plan Payment.—Whenever you determine that an individual's EGHP should be billed as primary payer, search your records for any services or items furnished that individual during the 12-month period prior to the month in which the current claim is being processed. Where such prior services or items are identified, bill the current EGHP for the prior services or items (unless the information available to the OPT provider about the prior services or items clearly shows why the EGHP should not be billed as primary payer). When EGHP payment is received for the prior services or items, submit an adjustment bill to the intermediary per §334.

Intermediaries may also identify prior claims for services or items furnished during the 12-month period to individuals who meet the criteria in §250.3, and on which primary benefits were paid. Where such a prior claim is identified, the intermediary will instruct the provider to bill the EGHP identified in the current claim for the prior services or items (unless the information available to the intermediary on the prior claim clearly shows why the EGHP should not be billed as primary). The provider will then submit an adjustment bill when the EGHP payment is received.

250.7 Action by OPT Provider Where Employer Group Health Plan Is Primary Payer.—

A. General.—Seek reimbursement from the EGHP before billing Medicare whenever there is indication that an employer plan is primary payer, i.e., where the services or items were rendered to an individual who meets the criteria in §250.3, and there is no evidence that the definitions in §250.2 are not met.

B. Submittal of Bill to Medicare after Employer Plan Has Made Payment.—If an EGHP pays primary benefits to an OPT provider, secondary Medicare benefits may be payable in accordance with §250.11 to supplement the amount paid by the EGHP. If the EGHP primary payment for a particular service or item is (1) less than your charges for Medicare covered services, (2) is less than the gross amount payable by Medicare (as defined in §250.11) and (3) you are not obligated to accept the EGHP payment as payment in full, submit a bill for secondary benefits in accordance with §334. If the EGHP payment equals or exceeds the gross amount payable by Medicare (as defined in §250.11), or equals or exceeds your charges for Medicare covered services or you are obligated to accept the EGHP payment as payment in full, no bill should be submitted. Any excess of the EGHP payment over the gross amount payable by Medicare is not subtracted from your Medicare reimbursement. If the EGHP denies your claim for primary benefits, submit a claim for primary Medicare benefits. (See §250.10.)

C. There may be instances where Medicare is secondary payer to more than one primary insurer. In such cases, the other insurers that are primary to Medicare will coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the others have paid primary payments, a secondary Medicare payment may be made per §334.

250.8 Crediting Expenses Toward Deductible and Coinsurance Amounts.—Expenses that would serve to meet the beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to you will be applied to satisfy a beneficiary's obligation to pay a Part B coinsurance amount.

250.9 Limitation on Right of OPT Provider to Charge a Beneficiary.—You may not charge a beneficiary or any other party for Medicare covered services if you have been paid by an EGHP an amount which equals or exceeds any applicable deductible or coinsurance amount. (See §334.)

250.10 Employer Plan Denies Claim for Primary Benefits.—Where an EGHP denies a claim for primary benefits for services or items rendered an individual who meets the criteria in §250.3, you should submit a claim for Medicare primary benefits. The Medicare claim must be annotated with the reason for denial of primary benefits by the EGHP. The EGHP may deny primary benefits for a variety of valid reasons; e.g., the employer does not employ 20 or more employees, the time limit for filing has expired, or the services are not covered under the EGHP. If the only reason for denial is the allegation that the EGHP is secondary to Medicare, conditional Medicare benefits will be paid subject to possible action against the insurer and employer by HCFA. See §334 for appropriate remarks to be entered on the billing form.

250.11 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Visits and Services.—If an EGHP payment is (1) less than your charges for Medicare covered services or items and (2) less than the gross amount payable by

Medicare (as defined below), and (3) you are not obligated to accept the EGHP payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment is the lower of:

A. The gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services; or

B. The gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is the current interim reimbursement amount for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP.

Detailed reimbursement and billing instructions are in §334.

250.12 Action by Intermediary to Recover Incorrect Payments.--If primary Medicare benefits are paid to an OPT provider and the intermediary learns that the services or items are covered under an EGHP, the intermediary will either recover directly from the EGHP or from the OPT provider. When recovering from an OPT provider, the intermediary will instruct you to file a claim with the EGHP for primary benefits, and upon receipt of the EGHP payment to refund to Medicare the amount Medicare paid less the amount received from the EGHP.

After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary will follow up periodically with you to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary will recover the Medicare primary payment from you subject to the overpayment recovery tolerance of $50, except where the reason you do not file a claim with the EGHP is because the beneficiary declines to sign the claims form. In that case, the intermediary will recover the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability. When you receive an EGHP refund, credit amounts paid by the EGHP toward the deductible and coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. You may retain any excess EGHP payment over the gross amount payable by Medicare. (See §250.7B.)

If duplicate payment was or will be made to an OPT provider, i.e., the OPT provider received or expects to receive both primary EGHP payments and primary Medicare benefits, the intermediary will seek to recover from the OPT provider the Medicare overpayment which is the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer, subject to the overpayment recovery tolerance of $50. If Medicare paid the OPT provider and the EGHP paid the beneficiary, the beneficiary is liable.

250.13 Incorrect EGHP Primary Payments.--Cases may arise where an EGHP has incorrectly paid you primary benefits. Where such cases come to the intermediary's attention, it will instruct you to bill Medicare as primary payer and to refund to the EGHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for non-covered services.

Protests and Appeals

255. PROVIDER PROTEST OF PAYMENT DETERMINATION

The outpatient physical therapy or speech pathology provider and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. (See Provider Reimbursement Manual, §§2426ff., for instructions concerning providers right to request a hearing on disputed cost reports.)

257. BENEFICIARY APPEALS (PART B)

A. Beneficiary Appeal Rights.—An individual dissatisfied with the denial of a request for payment of Part B benefits or the amount of such benefits paid is entitled to a review by the intermediary or carrier. If dissatisfied with the promptness with which his initial request for payment is acted upon or with the outcome of the review determination, he is entitled to a hearing by the intermediary's or carrier's hearing officer.

Effective October 31, 1982, a claimant's right to a Part B fair hearing is dependent upon a showing that there is $100 or more in controversy. Any appellant who received notice of review dated prior to October 31, 1972, was not subject to the $100 limitation.

B. Handling Beneficiary Protests.—Patient protests concerning entitlement to Part B benefits, e.g., enrollment, premium payment, should be referred to the social security office. Protests concerning the denial, amount, or promptness of payment for items or services furnished by the provider under medical insurance, if simply amenable to explanation or correction, should be handled by the provider. If the beneficiary is still dissatisfied, he should be referred to his social security office. The social security office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The social security office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

258. REOPENING AND REVISION OF MEDICARE CLAIMS DECISIONS

An initial or revised determination on a Part A or Part B Medicare claim may be reopened for any reason (and revised if found to be incorrect) within 1 year after the date of the decision.

After 1 year but within 4 years after the date of the initial decision, a determination may be reopened for "good cause," i.e., because (1) new and material evidence is furnished, (2) a clerical error has been made, or (3) there is an error on the face of the evidence; i.e., on the basis of all of the evidence on file at the time the decision was made, it is clear that the decision was incorrect.

A determination may be reopened at any time, if (1) the decision was procured by fraud or similar fault; or (2) correction of a clerical error or an error on the face of the evidence would make the decision more favorable to the claimant.

Outpatient Physical Therapy and Speech Pathology Services

A205.3 Outpatient Physical Therapy or Outpatient Speech Pathology Services Furnished Under a Plan.—Prior to the Omnibus Reconciliation Act of 1980 only a physician was permitted to establish the required plan of treatment for outpatient speech pathology services. Effective January 1, 1981, a plan of treatment for outpatient speech pathology services may be established by either the physician or the speech pathologist providing such services. Any changes to a plan of treatment established by such speech pathologist must be in writing and signed by that pathologist or by the attending physician. A speech pathologist, however, may not alter a plan of treatment established by a physician.

The requirements that a patient be under the care of a physician and that there be periodic review of the plan of treatment remain unchanged.

Cross refer: § 205.3

Outpatient Physical Therapy and Speech Pathology Services

IM 205.3 Outpatient Physical Therapy or Outpatient Speech Pathology Services Furnished Under a Plan.--Prior to the Medicare and Medicaid Budget Reconciliation Amendments of 1984 only a physician was permitted to establish the required plan of treatment for outpatient physical therapy services. Effective July 18, 1984, a plan of treatment for outpatient physical therapy services may be established by either the physician or the qualified physical therapist providing such services. Any changes to a plan of treatment established by such physical therapist must be in writing and signed by that physical therapist or by the attending physician. A physical therapist, however, may not alter a plan of treatment established by a physician.

The requirements that a patient be under the care of a physician and that there be periodic review of the plan of treatment remain unchanged.

Cross refer: §§202A, 205.1, 205.2, 205.3, 205.5

IM 245 WORKERS' COMPENSATION — GENERAL INFORMATION

IM 247 SERVICES REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO FAULT INSURANCE

IM 249 LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

IM 250 LIMITATION ON PAYMENT FOR SERVICES TO THE EMPLOYED AGED AND THE AGED SPOUSES OF EMPLOYEES WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

Private Cause of Action.—Effective for items and services rendered on or after January 1, 1987, if an automobile medical or no fault carrier, EGHP, or an entity responsible for payment under a workers' compensation law or plan fails to pay primary benefits as provided in section 1862(b)(1), (b)(2) and (b)(3) of the Act or fails to make appropriate reimbursement to Medicare when it has paid for covered services, the beneficiary and the provider, physician or supplier have a right to take legal action against the automobile medical or no fault carrier, EGHP, or responsible entity and to collect double damages. This is in accordance with section 1862(b)(5) of the Act as amended by section 9319 of the Omnibus Budget Reconciliation Act of 1986.

IM 251 MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

A. General.—Section 9319 of the Omnibus Budget Reconciliation Act of 1986 made Medicare secondary payer to "large group health plans" for "active individuals" (as defined in C3 below) under age 65 entitled to Medicare on the basis of disability. Under the law a large group health plan (LGHP) may not "take into account" that an "active individual" is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member, as explained in paragraph C.3. below. The following provides interim instructions dealing with implementation of this provision. In addition, the instructions in §§250.7 - 250.13 should be applied in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" as defined in paragraph C1 below, for the purpose of applying them to disabled individuals.

B. Effective Date.—This provision is effective for items and services furnished on or after January 1, 1987 and before January 1, 1992. The effective dates are fixed by law.

C. Definitions.—

1. Large Group Health Plan.—A "large group health plan" means any health plan of, or contributed to by, an employer or employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term employer for purpose of this provision has the same meaning as the term has for purpose of the working aged provision. That definition is in §250.2A. It includes the Federal Government and other governmental entities. Note, however, that the tax penalty for nonconforming large group health plans does not apply to Federal and other governmental entities. (See paragraph I below.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceding calendar year is considered to meet the above definition of LGHP. If the plan is a multiemployer plan, such as a union plan, which covers employees of some small employers and also employees of at least one employer that meets the 100 or more employees requirement, Medicare is secondary for all employees enrolled in the plan including those that work for small employers. Note that this differs from the rule for multiemployer plans under the working aged. (See §250.4G.)

2. Nonconforming Large Group Health Plan.—A "nonconforming large group health plan" means an LGHP that at any time during the calendar year takes into account that an active individual is eligible for or receives benefits based on disability, e.g., an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with paragraph C.3. below.

NOTE: Although the term "large group health plan" includes a plan for former employees or persons formerly associated with the employer in a business relationship, or their families, these individuals are not included within the definition of "active individual" in 3 below, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes. (See the tax penalty described in paragraph I below.)

3. Active Individuals Subject to This Limitation on Payment.—An "active individual" is an employee, an employer (e.g., proprietor or partner), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees) or a member of the family of any of these persons such as the spouse, parent or child of such an individual. Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In general, an individual who is receiving any payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA) will be considered an employee. This includes individuals receiving sick pay or disability benefits on which FICA taxes are payable.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. This occurs, for example, in cases where the individual's disabling condition continues but the individual is permitted to test his/her ability to work under the "trial work period" provisions of the law, or where the disabled individual returns to work and qualifies for continuation of Medicare coverage for 2 years after disability cash benefit entitlement ends.

Usually, however, the disabled person is the "family member" of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is not working, but who is covered under an LGHP of a spouse, parent, or any other family member is considered to be an "active individual."

D. Individuals Not Subject to this Limitation on Payment.—Medicare is not secondary for:

1. Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. However, in accordance with §249, Medicare is secondary payer for persons under age 65 with ESRD during a period of up to 12 months regardless of the number of employees.

2. Individuals who are covered by an EGHP of employer(s) of less than 100 employees, unless the EGHP is a multiemployer plan in which there is at least one employer of 100 or more employees. (See paragraph C.1. above.)

3. Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee or the spouse of a retired former employee.

E. Action by OPT Providers to Identify Individuals Subject to This Limitation on Payment.—Identify individuals who meet the conditions in Paragraph C.3. by asking every Medicare beneficiary under age 65 (1) if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and, (2) if so, whether the individual has group health coverage through an employer. If the individual responds affirmatively to both questions, request the name and address of the employer plan and the individual's identification number and bill the plan for primary benefits, except where you have information that clearly shows that the employer plan is not primary payer. If the individual responds that he or she does not meet either (1) or (2) above, or you have otherwise determined that the employer plan is not primary payer, bill Medicare for primary benefits and annotate item 57A on Form HCFA-1450, "Medicare."

Retain a record of this development or other information on which you based your determination that Medicare is primary payer for audit purposes and to ensure that you have developed for other primary payer coverage.

F. When Medicare Can Pay Secondary Benefits.—If you bill the employer plan first, Medicare may pay secondary benefits in accordance with §250.11, to supplement the employer plan payment, only if all of the following conditions are met:

1. the plan payment is less than the OPT provider's charges for Medicare covered services, and

2. the plan payment is less than the gross amount payable by Medicare (as defined in §250.11), and

3. the OPT provider does not accept and is not obligated to accept the plan's payment as payment in full. Refer to the billing instructions in §334 as appropriate.

G. Recovery of Primary Medicare Payments.—Under the law, the government may recover incorrect primary Medicare benefits from any LGHP which is primary payer. To recover Medicare payments the government:

1. may bring legal action against the LGHP and may collect double damages.

2. may take legal action to recover its benefits from any entity that has been paid by the LGHP for items and services furnished an individual who meets the conditions in paragraph C.3.

3. may join or intervene in any legal action against the LGHP related to the events that gave rise to the need for the items or services.

4. is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from an LGHP.

H. Claimants' Right to Take Legal Action Against Large Group Health Plan.—Any claimant including an individual who received services, and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

I. Tax Penalty for Noncompliance.—An excise tax is imposed by Section 5000 of the Internal Revenue Code (IRC) on any employer or employee organization that contributes to a nonconforming LGHP (see paragraph C2 for definition) during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

J. Identification of Cases and Action Where There is Indication of LGHP Coverage In Prior Claims.—Whenever you determine that an individual's employer plan should be billed as primary payer for items or services furnished on or after January 1, 1987, search your records for any prior claims on which Medicare paid primary benefits for services rendered that individual on or after January 1, 1987, on which there has not been a valid prior LGHP denial. When you identify such claims, bill the plan for the prior stays. When the employer plan payment is received you should submit an adjustment bill to the intermediary. Refer to §250.12 for further guidance regarding recovery of incorrect Medicare benefits where an employer plan may pay primary benefits if billed.

Intermediaries will also seek to identify prior claims for items and services furnished on or after January 1, 1987 to beneficiaries for whom Medicare is secondary in accordance with paragraph C.3. and for which Medicare paid primary benefits. Where such a prior claim is identified, the intermediary will instruct you to bill the employer plan identified in the current claim for the prior stay. Submit an adjustment bill when the employer plan payment is received.

IM 257. BENEFICIARY APPEALS (PART B)

A. General.—Section 9341 of the Omnibus Budget Reconciliation Act of 1986 (OBRA) (Public Law 99-509) provides for Administrative Law Judge (ALJ) hearings and judicial review for Part B claims denials, subject to minimum amounts in controversy. Section 9313(b) reaffirms the right of beneficiaries to appeal both Part A and Part B technical denials of home health benefits, e.g., denials for failure to meet the homebound or intermittent nursing care requirements.

B. Contractor Fair Hearing.--The contractor fair hearing is a prerequisite for an ALJ hearing. If less than $500 is in controversy following the contractor hearing officer's decision, no further appeals are available.

C. ALJ Hearings and Judicial Review for Part B Denials.—A person (including a provider or physician entitled to a hearing under §1879 of the Act) who is dissatisfied with the contractor hearing officer's decision on a Part B claim in which the amount remaining in controversy is at least $500, is entitled to a hearing before an ALJ. If at least $1,000 remains in controversy following the ALJ's decision, the claimant is entitled to judicial review before a Federal district court judge. This provision applies to items and services furnished on or after January 1, 1987.

D. Determining Amount in Controversy.—Section 9341 provides that in determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if they involve:

1. The delivery of similar or related services to the same individual, or

2. Common issues of law and fact arising from services furnished to two or more individuals.

Until new regulations are promulgated, follow the current rules for aggregating Part A and Part B claims. These rules are found in the regulations, for Part A, at 42 CFR §405.740 and, for Part B, at 42 CFR §405.820(b). The interim application of the pre-existing rules will not prejudice the rights of any claimant since the pre-existing rules respecting aggregation are less restrictive than the aggregation requirements of §9341.

E. Time Periods for Filing for Hearings.—Where Part B benefits are denied, the claimant has the right to a contractor hearing if at least $100 is in controversy and following that, an ALJ hearing, if at least $500 remains in controversy. (See B. and C. above.)

A contractor fair hearing (amount in dispute at least $100) must by regulation be requested within 6 months of the date of the review determination. An ALJ hearing (amount remaining in dispute after the contractor hearing at least $500) must by law be requested within 60 days of the date of receipt of the contractor hearing officer's decision.

F. Methods of Requesting Hearing.--The request for contractor fair hearing must be in writing and filed with the intermediary or a SSO. It may be any written expression of dissatisfaction with the intermediary review determination or a filing of Form HCFA-1965 -- "Request for Hearing -- Part B Medicare Claim." The SSO forwards the request for hearing to the appropriate intermediary.

G. Action by Intermediary Upon Receipt of Request for Hearing.--When a request for contractor hearing is filed, the intermediary notifies the claimant or representative that the contractor hearing officer will be contacting him about the request. Then the intermediary forwards the case file to a hearing officer who will take one of two actions:

1. Dismiss the hearing request if the hearing officer believes there is under $100 in controversy; or

2. Process the hearing request if the hearing officer believes that the amount in controversy is at least $100.

H. Hearing Decision.--The hearing officer's decision should contain the following appeals right language depending on the amount of benefits in controversy:

1. Amount Remaining in Controversy Is At Least $500.--"On the basis of this decision, I have determined that there is $_______ in question. Therefore, you may request a hearing by an Administrative Law Judge (ALJ) if you do not agree with this decision. You must request the hearing within 60 days of the date of receipt of this letter.

Write to me or contact any social security office if you want a hearing. Your request will be sent to the ALJ. The ALJ will then advise you what you have to do to prepare for the hearing."

2. Amount in Controversy Below $500.--"On the basis of this decision, I have determined that there is $______ in question. Therefore, there are no other levels of appeal available to you. However, if you think I have made a mistake you may ask me to open the case again. To do this you must write me as soon as possible. Include with your letter any additional information you may have which you feel may result in a more favorable decision."

I. Hearing Officer Action Upon Receipt of Request for ALJ Hearing.--When the contractor hearing officer, following his decision, receives a request for an ALJ hearing in which the amount remaining in controversy is at least $500, the hearing officer will take the following action:

1. New Evidence.--If any new evidence is submitted with the hearing request, the hearing officer reviews the case file to determine if the claim(s) may be reversed fully in favor of the claimant. If a full reversal is in order, the hearing officer prepares a decision containing the following elements:

- A clear statement of the issues,
- An explanation describing the reasons why a fully favorable decision is possible, with reference to the facts and evidence in the case,
- A statement of the statutory or regulatory basis for the decision,
- The decision, i.e., what the claimant can expect, and
- Signature of the HO.

The hearing officer forwards the full reversal decision to the claimant; then, he forwards the case file to the intermediary for effectuation of the decision. (A full reversal decision is actually a reopening and revision of the hearing officer's decision.)

2. Case File to ALJ.--Unless the claim(s) warrants a full reversal, the hearing officer forwards the file to the ALJ. Prior to forwarding the file, he reviews it carefully to ensure that all available evidence is included. If a partial reversal appears possible, based on any new evidence submitted, he includes that in an explanation to the ALJ.

J. Limitation on Authority of ALJs and Courts.--Section 9341 of OBRA stipulates the following limitations on the authority of ALJs and the Courts to rule on appealed Medicare claims:

1. ALJs have no authority to overturn national coverage determinations made by HCFA under §1862(a)(1) of the Act, i.e., determinations that a particular category of items or services is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. However, the ALJ will determine whether the "limitation of liability" rules in 42 CFR 405.332 were applied correctly, i.e., whether the beneficiary or provider (or both) knew or could reasonably have been expected to know that the items or services were not covered. Although the substantive national coverage determination may not be overturned by an ALJ, it is subject to judicial review, as limited as provided in paragraph 2.

2. In judicial review of the ALJs' decisions, courts have no authority to overturn a national coverage determination made under §1862(a)(1) of the Act solely on the grounds that the coverage rule relied upon in making the determination was not issued in accordance with the notice and comment procedures of the Administrative Procedure Act. In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it must remand the matter to the Secretary for additional proceedings to supplement the record. The court may not determine that an item or service is covered except upon review of the supplemented record.

3. Regulations and policy instructions initially issued prior to January 1, 1981 which concern a method for determining the amount of payment under Part B are not subject to judicial review.

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300. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. No billing form should be forwarded without the correct claim number. It is important that the claim number on this card be accurately recorded on the billing form since the case cannot be processed if the number is missing or incorrect.

Exhibit 1, §399 of this chapter shows the health insurance cards, and §307 explains the numbering system as an aid in recognizing valid numbers.

Ask each patient who gives his age as 65 or older or a younger patient who possibly has entitlement to Medicare as a disability beneficiary or under the provisions for coverage of persons needing kidney transplantation or dialysis, for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within 3 months of age 65 and has not yet applied for health insurance entitlement, advise him to contact the social security office. You may wish to arrange with the social security office to routinely bring such cases to their attention.

A health insurance card is acceptable without a signature, but the patient should be asked to sign it.

302. SOCIAL SECURITY AWARD CERTIFICATE AND TEMPORARY NOTICE OF ELIGIBILITY

An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

A. Social Security Award Certificate.—Health insurance beneficiaries receive a Social Security Award Certificate, SSA-L30-C1 (see Exhibit 2, §399) showing the health insurance claim number, dates of entitlement to Part A and Part B, and containing the following statement:

> "This notice may be used if Medicare services are needed before you receive your health insurance card."

B. Temporary Notice of Eligibility.—When a person 65 years or older needs immediate medical services, the social security office may issue a Temporary Notice of Medicare Eligibility (see Exhibit 3, §399) before a Social Security Award Certificate or health insurance card is issued.

The patient's name and health insurance claim number shown on these notices should be entered on the billing form.

306. UTILIZATION NOTICE OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card or one of the notices described in §302, he may have a utilization notice or explanation of benefits which shows his claim number. Such notices are sent to the beneficiary by the Social Security Administration, the intermediary, or carrier after payments are made under Part A or Part B. These notices, if current, may also indicate to the provider the patient's deductible status under medical insurance.

307. IDENTIFYING HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9-digit numbers with letter suffixes, e.g., 000-00-0000-A. However, it might also be a 6 or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix/suffix of his claim number to change.

A. Health Insurance Claim Numbers Assigned by SSA.—The potentially valid health insurance claim number assigned by SSA is a 9-digit number followed by one of the following suffixes:

A, B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT
C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, etc.
D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DD, DG, DH, DJ, DK, DL, DN, DP, DQ, DR, DT, DV, DW, DY
E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM
F1, F2, F3, F4, F5, F6, F7, F8
HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9
HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, HC9
J1, J2, J3, J4 (See Note 1)
K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM (See Note 1)
W, W1, W2, W3, W4, W5, W6, W7, W8, W9, WC, WF, WG, WJ
M, M1, and T (See Note 2)
TA, TB, TC, TD, TE, TF, TG, TH,
TJ, TK, TL, TM, TN, TP, TQ, TR,
TS, TT, TY, TV, TW, TX, TY,
TZ, AND T2, T3, T4, T5, T6, T7, T8

Note No. 1: Supplementary medical insurance entitlement may exist for all J and K suffixes. However, for subscripts J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL, and KM entitlement to hospital insurance benefits is for a qualified uninsured individual who secures coverage on a voluntary basis.

NOTE No. 2: Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits and has refused hospital insurance benefits.

Suffix T indicates the individual is entitled to hospital and medical insurance and is not entitled to monthly social security benefits.

B. HICNs Assigned by the Railroad Retirement Board.--The RRB began using the social security number in their numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers; these were assigned in numerical sequence and have no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. (In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6-digits; add sufficient zeros between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

All-Inclusive List of Potentially Valid RRB HICNs.--

A-000000, or
A-000-00-0000

MA-000000, or
MA-000-00-0000

WA-000000, or
WA-000-00-0000

WD-000000, or
WD-000-00-0000

CA-000000, or
CA-000-00-0000

WCA-000000, or
WCA-000-00-0000

WCD-000000, or
WCD-000-00-0000

PA-000000, or
PA-000-00-0000

PD-000000, or
PD-000-00-0000

H-000000

MH-000000

WH-000000

WCH-000000

PH-000000

JA-000000

307.1 Change in HICNs.--Changes in an individual's entitlement to social security or railroad retirement benefits may result in an individual being assigned a completely different HICN. An example is an individual not entitled to monthly benefits (000-00-0000) who marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B).

308. CONTACTS WITH THE SOCIAL SECURITY OFFICE TO OBTAIN HICNs

When a beneficiary cannot furnish his HICN, you may request it from the SSO. Establish a working procedure with the SSO.

Obtain a signed statement from the beneficiary authorizing you to file a Medicare claim on his behalf.

Under the Privacy Act, the SSO need not keep a record of the disclosure of the HICN if you advise it that you have this signed statement. Retain the signed request for the release of the claim number for 5 years following the month in which the request was made.

If you are unable to obtain the necessary signature, the SSO will provide the claim number but is required by the Privacy Act to keep a record of the disclosure. Therefore, obtain the beneficiary's written authorization whenever possible.

NOTE: The SSO will also help a beneficiary replace a lost or destroyed HICN.

310. DETERMINING HOW MUCH TO CHARGE PATIENT BEFORE BILLING IS SUBMITTED

Ask the patient if he has any evidence that he has met the deductible, such as an Explanation of Medicare Benefits form. (See §306.) You may also take into account any other available information on the patient's deductible status.

Where the deductible is known to be met, collect 20 percent of the charges for outpatient physical therapy. Where the deductible is known to be met in part, collect no more than the unmet deductible and 20 percent of the remaining charge. When the deductible is not met or its status is unknown, collect no more than the cash deductible and 20 percent of the balance. Once you have billed for outpatient physical therapy services, do not collect or accept any additional money from the patient for such services until the intermediary has notified you how much of the deductible has been met. Otherwise, you are likely to receive duplicate payments.

311. IDENTIFYING OTHER PRIMARY PAYERS PRIOR TO BILLING

Medicare is secondary payer under certain circumstances. The following chart helps you to recognize the circumstances under which Medicare does not pay as primary and to identify the responsible party. Place a copy of this completed chart or equivalent information in your files to ensure that you have developed for other primary payer coverage. This may be retained in paper, microfilm, or microfiche.

Medicare is not the primary payer:

- o If the items or services have been, or can reasonably be expected to be paid under a WC law or plan of a State or of the United States including the Federal Black Lung Program. (See §245.);
- o If the items or services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance. (See §247.);
- o During a period up to 12 months, if the beneficiary is entitled to benefits solely on the basis of end stage renal disease (ESRD) and is covered by an Employer Group Health Plan (EGHP). (See §249.);
- o If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP. (See §250.); or
- o If the beneficiary is under age 65, disabled, and covered by a large group health plan (LGHP) as a current employee, self-employed individual, family member of such an employee, or as a self-employed individual. (See §334.A for the definition of LGHP.)

The following chart lists questions to ask Medicare beneficiaries when establishing the plan of treatment. Use it as a guide to help identify other payers listed above which may be primary to Medicare. Before utilizing this chart see §§332-335 for information regarding situations in which Medicare is secondary. Beginning with Part 1, ask the beneficiary each question in sequence. Comply with any instructions which follow an answer you have checked. If the instructions direct you to go to another part, have the beneficiary answer, in sequence, each question under the new part. If an answer you have checked is followed by the message "STOP," bill that beneficiary's services to the insurer indicated.

NOTE: There may be situations where more than one insurer is primary to Medicare (e.g., automobile insurer and EGHP). Be sure to identify all possible insurers.

Part I

1. Was illness/injury due to a work related accident/condition and covered by a WC plan or the Federal Black Lung Program?

____ yes;

Name and address of WC plan
or Federal Black Lung Program ______________________________

Patient's policy or identification number ________________

STOP: WC OR FEDERAL BLACK LUNG PROGRAM IS PRIMARY PAYER.

____ no; GO TO PART II

Part II

1. Was illness/injury due to nonwork related accident?

___ yes.

___ no; GO TO PART III

2. What type of accident caused illness/injury?

___ automobile;

Name and address of automobile insurer ____________________________

Insurance claim number ______________________

STOP: AUTO INSURER IS PRIMARY PAYER.

___ other;

3. Was another party responsible for this accident?

____ yes;

Name and address of any liability insurer ____________________________

Insurance claim number ______________________

STOP: LIABILITY INSURER IS PRIMARY PAYER.

____ no; GO TO PART III

Part III

1. Is the patient aged 65 or over?

___ yes.

___ no; GO TO PART IV

2. Is the patient undergoing kidney dialysis for ESRD?

___ yes; STOP: MEDICARE IS PRIMARY PAYER.

___ no.

3. Is the patient employed and covered by the Employer's Group Health Plan?

___ yes;

Name and address of EGHP ______________________________

Patient's identification number ________________

STOP: EGHP IS PRIMARY PAYER.

___ no;

4. Is the patient's spouse employed?

___ yes;

___ no; STOP: MEDICARE IS PRIMARY PAYER.

5. Is the patient covered under the group health plan of the spouse's employer?

___ yes;

Name and address of EGHP ______________________________

Patient's identification number ________________

STOP: EGHP IS PRIMARY PAYER.

___ no; STOP: MEDICARE IS PRIMARY PAYER.

Part IV

1. Is the patient entitled to benefits solely on the basis of ESRD?

___ yes.

___ no; GO TO PART V

2. Is this patient covered by an EGHP?

___ yes;

Name and address of EGHP ______________________________

Patient's identification number ____________________

___ no; STOP: MEDICARE IS PRIMARY PAYER.

3. Has the patient been undergoing kidney dialysis for more than 12 months or been entitled to Medicare for more than 12 months?

___ yes; STOP: MEDICARE IS PRIMARY PAYER.

___ no;

4. Is the patient within a 12-month period as defined in §333?

___ yes; STOP: EGHP IS PRIMARY PAYER.

___ no; STOP: MEDICARE IS PRIMARY PAYER.

Part V

1. Is the patient a disabled Medicare beneficiary under age 65?

___ yes;

___ no; STOP: MEDICARE IS PRIMARY PAYER

2. Is the patient covered by a group health plan (GHP) based on patient's own employment or employment of a spouse or parent?

___ yes;

Name and address of EGHP ______________________________

Patient's Identification Number ______________

STOP: EGHP IS PRIMARY PAYER

___ no; STOP: MEDICARE IS PRIMARY PAYER

312. PROVIDER SUBMISSION OF ELECTRONIC MEDIA CLAIMS DATA (EMC)

Providers served by intermediaries with capability to accept claims on magnetic tape or other machine readable medium may utilize the capabilities of automated systems to submit EMC data in lieu of hardcopy data. All providers utilizing or developing this capability, whether in-house or through a billing service, must meet the level of accuracy of EMC required by the intermediary.

Intermediaries capable of receiving EMC are required to canvass their providers having automated systems to determine provider capability and willingness to submit EMC data. Providers not canvassed, but interested in participating in this activity, should contact their intermediary.

312.1 Requirements for Submission of EMC Data.—HCFA's goal is to have all electronic billers submit EMC data to intermediaries using the National Standard Specifications described herein. In support of this goal, intermediaries are required to receive and process claims reported by billers electronically if the claims adhere to the file and record formats and utilize the data set described in Addendum A (Record Formats), Addendum B (Data Definitions), Addendum C (Coding Structures).

Intermediaries may not develop and use file and record formats for EMC that do not conform to the National Standard Specifications. HCFA expects that intermediaries will give payment priority to electronically submitted bills. Intermediaries and providers must continue to comply with data requirements.

A. Provider Representative Certification.—Accompany the initial group of claims submitted to an intermediary under these instructions with a covering letter, signed by your representative which includes the following statement: "In submitting EMCs, I understand that I am certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and recertifications (PRO certifications where applicable) are on file and anyone who misrepresents or falsifies essential Medicare claims information, may, upon conviction be subject to fine and imprisonment under Federal law." Resubmit the statement annually, or upon a change in provider representative if that occurs before the year is up.

B. Claims Submission.—

- Claims data may be submitted in periodic groups/batches at intervals mutually established between the intermediary and you.
- To the extent possible, consolidate and submit multiple beneficiary services received during the same day as one claim; e.g., when the beneficiary receives services from more than one clinic or department.

C. Control.—Your system must have the capability to resubmit lost or garbled claims data or unreadable tapes, cassettes, floppy disks, or whatever other medium is used, and be able to reassociate data found to be in error with the original claim for correction and resubmission.

D. Retention.—Retain all applicable source data in accordance with requirements and make it available for periodic intermediary verification.

312.2 File Specifications, Records Specifications, and Data Element Definitions for EMCs.—This material was developed by HCFA in consultation with the National Association for Home Care, the Blue Cross Association, the Health Insurance Association of America, the Medicaid Systems Technical Advisory Group, and CHAMPUS.

In addition to accommodating the requirements for Medicare claims submittal, and the Medicaid and CHAMPUS counterparts to such billings, it is designed to meet the basic billing needs of private health insurers.

Provision has been made for users to expand the file and record format to accommodate needs of a specific locality or type of health insurance coverage. If an entire physical segment is desired within a subset, record types n5 through n9, where n represents 1 through 9, are available for local or specified use. Within the nationally defined physical segments, where space permits, a portion is set aside for local use. The File and Record Formats are described in Addendum A. The data elements are listed alphabetically and defined in Addendum B. Coding structures for data represented by codes are defined in Addendum C.

312.3 Return of Beneficiary Data to Provider Billing Services.—Beneficiary eligibility and utilization data is returned directly to you unless you have obtained written authorization from the beneficiary to release such data to a billing service. If you wish to have eligibility and utilization information released to a billing service, modify forms (other than biling forms) currently used to obtain beneficiary authorization for release of Medicare data to a billing service. Notify the intermediary by a letter signed by the provider representative that such beneficiary authorizations are being obtained routinely and retained in your files. (See §312.1B.)

313. REDUCTION IN REIMBURSEMENT DUE TO P.L. 99-177, P.L. 100-119, and P.L. 100-203

A. General.—P.L. 99-177 requires a reduction in all Medicare program payments when the total Federal budget deficit exceeds set limits. P.L. 100-203 sets the reduction in program reimbursement at 2.324 percent for the period November 21, 1987 through March 31, 1988. You will be informed of the amount of the reduction for each Federal FY by your intermediary.

The intermediary reduces all Medicare program payments after applying deductible, coinsurance, and any applicable Medicare Secondary Payer (MSP) adjustments. It reduces each claim or interim payment (including PIP).

B. Definitions.—

Date of Service: The intermediary applies the reduction for all services for which the through date on the bill is on or after November 21, 1987. You may bill earlier services separately to avoid the reduction.

Reduction Amount: Although the reduction is 2 percent for FY 1988, 2.324 percent must be withheld beginning November 21, 1987 through March 31, 1988.

The amount of reduction is determined by October 15 for each year. For FYs after 1988, your intermediary will inform you of the specific percentage by which bills are reduced after the final determination of the amount is made. Intermediaries will hold any bills for services on or after October 1 until they receive the amount of reduction from HCFA.

C. Changes Required in Bill Payment Procedures.—You may bill separately for all services prior to November 21, 1987, in order to avoid the reduction of the entire bill. Split any bills spanning the effective date of the reduction, i.e., November 21, 1987 or the Federal FY.

The intermediary reduces all bills with dates of service or through dates on or after November 21, 1987. It will not develop bills which may contain earlier services and will not accept adjustment bills to correct earlier bills spanning November 21, 1987 or the beginning of a new Federal FY for services billed on a monthly basis.

You can expect reduction on final payments and interim payments (cost based interim payments). When payment is for laboratory services, the intermediary makes the reduction after it decides whether the charge or fee schedule is lower.

The intermediary adjusts payment amounts, not payment rates. It applies the reduction to the amount that would have been paid before P.L. 99-177, i.e., after reduction for deductible, coinsurance, and MSP. This provides a slightly higher payment to you than applying the percentage reduction before deductible, coinsurance, and MSP.

You may not collect the reduction amount from beneficiaries.

314. CLAIMS PROCESSING TIMELINESS

A. Claims Processing Timeliness Requirements.--"Clean" claims must be paid or denied within the applicable number of days from the date of their receipt as follows:

Time Period for Claims Received	Applicable Number of Days
02-01-86 thru 09-30-87	30
10-01-87 thru 09-30-88	26
10-01-88 thru 09-30-89	25
10-01-88 and later	24

NOTE: For interest payments the time period begins 04-01-87.

See subsection D for the definition of a clean claim. All claims (i.e., paid claims, partial and complete denials, no payment bills), including EMCs are subject to the above requirements.

The count is started on the day after the receipt date and ends on the date payment is made. For example, for claims received October 1, 1987 through September 30, 1988 if this span is 26 days or less the requirements is met.

B. Payment Floor Standards.--Your intermediary will not pay, issue, mail, or otherwise reimburse for any claim it receives from you within the waiting period indicated below. The length of the waiting period is determined by the date a claim is received. Your intermediary starts its count on the day after the day of receipt. For example, a claim received July 1, 1988 can be paid on or after July 12, 1988.

Claims Receipt Date	Waiting Period (Calendar Days)
07-01-88 thru 09-30-88	10
10-01-88 thru 09-30-89	14

NOTE: No payment claims are not subject to the payment floor standards.

C. Interest Payment on Clean Claims Not Paid Timely.--Interest must be paid on clean claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A. For example, a claim received on October 1, 1987, must have been paid before the end of business on October 27, 1987. Interest will not be paid on:

- Claims requiring external investigation or development by your intermediary;
- Claims on which no payment is due; or
- Full denials.

Interest is paid on a per bill basis at the time of payment.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6 month basis. Interest is calculated using the following formula:

Reimbursement amount x rate x days divided by 365 = interest payment.

The interest period begins on the day after payment is due and ends on the day of payment.

EXAMPLE: Date received - January 1, 1989
Payment due - on January 26, 1989
Payment made - February 09, 1989
Interest begins - on January 27, 1989
Interest ends - February 09, 1989
Days for which interest due - 14 days
Amount of reimbursement = $100
Annual interest rate = 9.75%

The formula is applied as follows:

$100 x .0975 x 14 divided by 365 = $.373 or $.37 when rounded to the nearest penny.

When interest payments are applicable, your intermediary indicates for the individual claim the amount of interest on its remittance record to you.

D. Definition of "Clean Claim".--A "clean" claim is one which:

o Your intermediary does not investigate or develop external to its operation on a prepayment basis; and

o Your intermediary receives a definitive query response within 7 days of its original query. A definitive query response is one which provides your intermediary with all the eligibility data needed to process the claim.

Examples are claims which:

o Pass all edits and are processed electronically;

o Are investigated within your intermediary's claims, medical review, or reimbursement office without the need to contact you, the beneficiary, or SSA;

- Are subject to medical review but complete medical evidence is attached by you or forwarded simultaneously with EMC records in accordance with your intermediary's instructions. If medical evidence must be requested, see first item under subsection E; or

- Are developed on a postpayment basis.

E. Other Claims.--Claims which do not meet the definition of "clean" are considered "other" claims. These include those which require investigation or development external to your intermediary's operation on a prepayment basis. In addition, if your intermediary does not receive a definitive query response within 7 days of its original query, the claim is considered an "other" claim regardless of whether it develops externally.

Examples are claims on which your intermediary:

- Requests additional information from you or another source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- Requests information or assistance from another contractor, e.g., development data obtained through the carrier-intermediary data exchange;

- Develops MSP information;

- Requests information necessary for a coverage determination;

- Performs sequential processing when an earlier claim is in development;

- Requeries because an original query has not been answered within 7 days; or

- Does not receive a definitive query response within 7 days of its original query date.

NOTE: If your intermediary is a Common Working File dependent intermediary, a claim is considered "other" if your intermediary continues to receive notification of claim recycling.

315. BILLING FOR SERVICES BY REHABILITATION AND PUBLIC HEALTH AGENCIES AND CORFS

Use Form HCFA-1450 to report services furnished on or after the provider's effective date of participation under the program. Rehabilitation and Public Health Agencies use the HCFA-1450 to bill for outpatient physical therapy or speech pathology services. CORFs use the HCFA-1450 to bill for services defined in §317.

A. When to Submit This Form.—You may submit this form on a timely cyclical billing basis. Submit a HCFA-1450 to the intermediary in all cases where services are rendered, regardless of whether the deductible has or has not been satisfied. Do not submit a HCFA-1450 if the patient is not enrolled under part B; if payment was made in full by a National Institutes of Health Grant, the Public Health Service, VA other governmental entity or liability insurance; for the period covered by the WC (including BL), automobile medical, and no-fault insurance or in the situations described in §§333 and 334, for an EGHP.

B. Scope of Waiver of Liability Provisions.—The basic premise of the waiver provision in section 1879 of the Social Security Act is that beneficiaries who did not know or had no reason to know that services were not covered are protected from liability in two specific types of denial situations: when the services were found to be not reasonable and necessary (which includes adverse level of care determinations), or when custodial care is involved.

If the beneficiary had knowledge or should have had knowledge of the noncoverage of services, the ultimate liability will rest with the beneficiary. When neither the beneficiary nor you knew or reasonably could have been expected to know that services were not covered, the program will accept liability. Where you had or should have had such knowledge and the beneficiary is protected from liability, liability will fall upon you; i.e., you should not charge the beneficiary for such services other than deductibles and coinsurance, even though no program payment will be made.

Ordinarily, the intermediary, upon review of the bill, considers the waiver provisions when it determines that services are not medically reasonable or necessary or constitute custodial care, sometimes, however, prior to the review of the bill, upon review of the medical evidence, the intermediary informs you that program payment may be made only through a certain date because the services are considered not medically reasonable or necessary or constitute custodial care. In such cases, bill only for the services rendered through the date given by the intermediary. Where such adverse coverage decision is made prior to the submission of the bill, inform the beneficiary immediately.

Coinsurance and deductibles are charged the beneficiary where he receives the benefit of this waiver provision.

C. Notifying Patient of Denial.—After reviewing the plan of treatment and you determine that the services to be furnished to the patient will not be covered, advise the patient (or his representative) in writing prior to rendering the services that the care is noncovered and no claim for Medicare reimbursement will be submitted.

If the beneficiary insists that you submit a claim for payment, indicate on the bill that it is being submitted at the beneficiary's request, and why you considered the care to be noncovered.

If during the course of the patient's treatment you are advised by the intermediary that the covered care has ceased, notify the beneficiary (or his representative) immediately.

316. BILLING FOR DURABLE MEDICAL EQUIPMENT (DME) AND ORTHOTIC/PROSTHETIC DEVICES

Section 4062 of P.L. 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA) requires that payment for DME furnished under the Part A home health benefit and Part B DME, orthotic and prosthetic devices be made on the basis of a fee schedule for items provided January 1, 1989 and later. HCPCS coding is required when billing for DME, orthotics and prosthetics. Deductible and coinsurance apply (see subsection C for application). The equipment is categorized into one of six classes:

- Prosthetic and orthotic devices;
- Inexpensive or other routinely purchased DME;
- Items requiring frequent and substantial servicing;
- Customized items;
- Capped rental items; or
- Oxygen and oxygen equipment.

See subsection D for detailed billing information for each class and Addendum D for appropriate HCPCS codes and definitions.

A. Billing for DME, Orthotic and Prosthetic Devices.--Bill DME on the HCFA-1500 to the local carrier. (See §320.2 for completion of the HCFA-1500.) If you do not have a provider number from the carrier, contact the carrier to secure one. Continue to bill your intermediary for orthotic and prosthetic devices on the HCFA-1450. Follow requirements for submission of the HCFA-1450 in §318.

B. Fee Schedule.--The carrier establishes the fee schedule for orthotics and prosthetics and furnishes it to your intermediary. Depending on the class location of a piece of equipment, payment is based on the particular class' fee schedule effective January 1, 1989. (See Addendum D.) In subsequent years, the fee schedule will be adjusted to reflect changes in the consumer price index for all urban consumers (CPIU) (U.S. city average). For local codes, the carrier provides information on the appropriate category and pricing to you for DME and to your intermediary for prosthetics and orthotics.

NOTE: All codes contained in Addendum D are paid on the basis of the fee schedule.

C. Application of Fee Schedule and Determing Payment and Patient Liability.--Your carrier is responsible for applying the correct fee schedule for payment of DME. Your intermediary is responsible for applying the correct fee schedule for payment of orthotic and prosthetic devices.

The carrier or intermediary uses the following rules on determining payment and patient liability for DME, orthotics and prosthetics:

- Payment.--To determine the Part B payment to you, the carrier or intermediary substracts any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiplies the remainder by 80 percent. This is the final payment.

o Patient Liability.—To determine the patient liability to you, subtract any unmet deductible from the actual charge and multiply the remainder by 20 percent. The result obtained plus the unmet deductible is the patient's liability.

D. Classes of Equipment.—The following defines the six classes of equipment and indicates whom to bill. (See Addendum D for HCPCS codes for each class.)

o Prosthetic and Orthotic Devices (Other Than DME).--These items consist of all prosthetic and orthotic devices excluding: items in the classes "Certain Customized Items" and "Items Requiring Frequent and Substantial Servicing," transcutaneous electrical nerve stimulators (TENS), parenteral/enteral nutritional supplies and equipment, and intraocular lenses. Other than these exceptions, payment for prosthetic and orthotic devices is made on a lump-sum purchase basis using the lesser of the fee schedule or the actual purchase charge. (See subsection E for payment considerations for TENS.)

Bill Prosthetic and orthotic devices under revenue code 274 to your intermediary.

Bill the carrier for TENS.

o Inexpensive or Other Routinely Purchased DME.—This is equipment with a purchase price not exceeding $150 or equipment which the Secretary determines is acquired by purchase at least 75 percent of the time. Payment is either through rental or purchase but the total payment amount for a particular item may not exceed the actual charge or fee for purchase. Payment is possible for maintaining and servicing purchased equipment. The rental fee includes service and maintenance.

Bill the carrier.

o Items Requiring Frequent and Substantial Servicing.—These are items such as ventilators, aspirators, IPPB machines, and nebulizers. Payment is generally made on a rental basis. For rentals, payment is made based on monthly fee schedule amounts until medical necessity ends. However, where the beneficiary has purchased an item of equipment in this category, monthly installments are paid equivalent to rental fee schedule amounts until the medical necessity ends, the fee schedule purchase price or actual charge has been reached, whichever comes first.

Bill the carrier.

o Certain Customized Items.—Due to their unique nature (custom fabrication, etc.) which makes them unsuitable for grouping together for profiling purposes, these are items for which the carrier has not established customary and prevailing charges. Other than HCPCS code E1220, the DME and orthotic/prosthetic items included in this category are not coded in the HCPCS. (This inlcudes those circumstances where an item which has a HCPCS code is modified to the extent that neither the original terminology nor the terminology of another HCPCS code accurately describes the modified item.) Payment is made for these items in a lump-sum based upon individual consideration for each item.

Also, payment for maintenance and servicing may be made when a manufactureres' warranty no longer provides coverage. There is no listing of codes in Addendum D pertaining to this class. Use HCPCS code L8499 when billing your intermediary for orthotics and prosthetics. Contact the carrier to obtain proper HCPCS codes for billing DME.

Bill the carrier for DME.

Bill your intermediary for othotic and prosthetics.

o Capped Rental Items (other items of DME).--These are DME items not covered by the categories described above. For these items of DME, payment is made on a rental or purchase basis. For rental items, payment is generally made on a monthly rental basis not to exceed a period of 15 continuous months except where the beneficiary has purchased an item of equipment without prior rental. In such cases, payment is made on monthly installments equivalent to rental fee schedule amounts until the actual charge for purchase is reached, the fee schedule amount for purchase is reached, or the medical necessity ends, whichever occurs first. Payment may be made for purchase even if the purchase was preceded by a period of rental. However, total payments for rental plus purchase may not exceed the amount that would have been paid had the equipment been continuously rented for 15 months. Therefore, if a purchase occurs during a period of continous use after 15 months of rentals have been paid, no payment may be made other than the reasonable and necessary charges for maintenance and servicing. (See subsection F for billing and payment considerations for maintenance and servicing and for continous use.)

Bill the carrier.

o Oxygen and Oxygen Equipment.--Generally, payment is made on a monthly basis. However, where a beneficiary has purchased an item of oxygen equipment monthly installments are paid equivalent to the fee schedule amounts until either the medical necessity ends or the fee amount for purchase of the equipment has been reached. (See subsection F for special billing requirements.)

Bill the carrier.

NOTE: For all the above classes of equipment except Capped Rental Items, payment is made for maintenance and servicing anytime the beneficiary purchases equipment if the warranty has expired. Payment is not made for maintenance and servicing if the beneficiary rents the equipment since maintenance and servicing are included in the rental payments. (See subsection F for discussion of Capped Rental Items.)

For all classes involving DME and/or oxygen except Capped Rental Items, contact the carrier for billing information for maintenance and servicing. The billed amount is paid if reasonable.

E. Special Payment Considerations.—The carrier or intermediary considers the following issues when processing claims:

o For rent/purchase decisions made before January 1, 1989, if the purchase price limitation has not been reached prior to January 1, 1989, the carrier applies the new provisions. Claims on or after that date, no matter when the initial delivery occurs, are in accordance with these provisions. Similarly, the 15 month limitation for capped rental items begins with the first month of rental without regard to when that period started;

o The carrier will not pay for replacement of equipment that is not purchased or for replacement of equipment where the 15-month rental period has expired;

o To permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, the carrier pays 10 percent of the purchase price of the item for 2 months prior to purchase;

o The carrier pays for equipment listed in the category "Needs Prescription Before Delivery" which is contained in Addendum D only when the supplier has a written order in hand prior to delivery. If the written order is not in hand prior to delivery, payment will never be made for the item even if a written order is subsequently furnished. If a similar item is subsequently provided by an unrelated supplier, who has a written order in hand prior to delivery, payment may be made; and

o The carrier or intermediary pays the reasonable and necessary charges for maintenance and servicing of purchased equipment. These include only those made for parts and labor that are not otherwise covered under a manufacturer's or supplier's warranty. The carrier or intermediary pays on a lump-sum, as needed basis, through individual consideration for that item. Payment may not be made for maintenance and servicing of rented equipment other than the maintenance and servicing fee established for capped rental items.

F. Billing and Payment Considerations For Maintenance and Servicing and For Continuous Use.—Consider the following issues:

o Payments During a Period of Continuous Use.—For capped rental items, payments may not exceed a period of continuous use of longer than 15 months. Neither a change in address nor a change in suppliers will extend the 15 month period. After 15 months of rental have been paid, you must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Medicare coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue.

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions may last up to 60 consecutive days plus the days remaining in the rental month (this does not mean calendar month, but the 30-day rental period) in which use ceases, regardless of the reason the interruption occurs. Thus, if the interruption is less than 60 consecutive days plus the days remaining in the rental month in which use ceases, do not begin a new 15-month rental period. Also, when an interruption continues beyond the end of the rental month in which the use ceases, payment is not made for additional rental until use of the items resumes. Establish a new date of service when use resumes. Unreimbursed months of interruption are not counted toward the 15-month limit.

If, however, the interruption is greater than 60 consecutive days (plus the days remaining in the rental month in which need ceases) and you submit a new prescription, new medical necessity documentation, and a statement describing the reason for the interruption which shows that medical necessity in the prior episode ended, a new 15-month period begins. If you do not submit this documentation, a new 15-month period does not begin.

If the beneficiary changes equipment to different, but similar equipment, the carrier reviews the claim to determine whether the beneficiary's medical needs have substantially changed and the new equipment is necessary. If so, a new 15-month period begins. Otherwise the current 15-month continues.

If the new configuration is a modification of existing equipment through the addition of medically necessary features (for example, a special purpose back is added to a wheelchair), the 15-month rental period continues for the original equipment and a new 15-month rental period begins for the added equipment.

For purposes of computing the 15-month period for capped rental items, the carrier begins counting the first month that the beneficiary continuously rented the equipment. For example, if the beneficiary began renting the equipment in July 1988, the rental month which begins in January 1989 is counted as the beneficiary's 7th month of rental. Therefore, if the equipment has been continuously rented prior to October 2, 1987, no further rental payments are made since the 15-month period is terminated before January 1, 1989. Payment for maintenance and service begins July 1, 1989.

If the beneficiary has reached (on a date of service prior to January 1989) the purchase price limitation on a rental claim, the carrier does not make any further rental payments. However, for capped rental items previously rented that have reached the purchase cap under the rent/purchase rules, claims for maintenance and servicing fees effective July 1, 1989 are paid.

o Maintenance and Servicing.--Bill for maintenance and servicing by adding the modifier MS to the HCPCS representing capped rental equipment. The carrier pays the reasonable and necessary charges for maintenance and servicing of purchased equipment. It does not pay for parts and labor that are covered under a manufacturer's or supplier's warranty. The carrier makes a lump-sum payment on an as needed basis based on its considerations for that item. Payment may not be made for maintenance and servicing of rented equipment other than the maintenance and servicing fee established for capped rental items.

For capped rental items which have reached the 15-month rental cap, the carrier pays claims for maintenance and servicing fees after 6 months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. For example:

o Date service begins:	1/5/88
o 15-month rental period ends: (1/5/88 + 15 months)	4/4/89
o 6-month period when no payment is made (4/5/89 + 6 months):	4/5/89 - 10/4/89
o Date maintenance and servicing payment may begin:	10/5/89
o Payment covers all maintenance and servicing through (10/5/89 + 6 months):	4/4/90

For capped rental DME, the maintenance and servicing fee is paid only once every 6 months.

G. Special Requirements for Billing Oxygen Claims.--Fee schedule payments for oxygen and oxygen equipment are all inclusive and represent a monthly rental payment allowance to a beneficiary. Accordingly, bill the carrier on a monthly basis for the oxygen equipment and contents furnished, if applicable. The carrier pays an additional fee for portable add on equipment under the situations indicated in subsection H.

The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed in liters per minute (LPM) and whether or not portable oxygen or a conserving device is also used. To receive the applicable payment adjustment, bills must indicate the appropriate HCPCS modifier as follows:

o If the prescribed amount of oxygen is less than 1 LPM, the modifier is QE. The monthly payment amount for stationary oxygen is reduced by 50 percent.

o If the prescribed amount of oxygen is greater than 4 LPM, the modifier is QG. The monthly payment amount for stationary oxygen is increased by 50 percent. The carrier conducts a prepayment medical review.

o If the prescribed amount of oxygen exceeds 4 LPM, and portable oxygen is prescribed, the modifier is QF. The monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on. The carrier conducts a prepayment medical review.

o If a conserving device is used with an oxygen delivery system ,the modifier is QH. No payment adjustment is made. Separate reporting is necessary for statistical and analysis purposes.

You may submit monthly bills as of the first rental service date in the case of initial rentals of an oxygen system or, no sooner than 30 days after the prior rental month's service date in the case of an established oxygen patient.

When submitting an initial claim for rental of a gas or liquid delivery system, units of oxygen contents furnished for the first month need not be included and the monthly payment amount should be allowed. However, for dates of service subsequent to the initial rental month, you should indicate actual content usage for the month being billed or, if billed prospectively, the actual content usage during the previous 30 days. Payment for other than than the initial rental month is the lower of the billed equipment and content charges or the monthly payment amount.

For stationary gaseous system contents, multiples of 50 cubic feet, rounded up, should be indicated. For example, if 73 cubic feet of oxygen is provided, the unit entry "02" should be made. For stationary liquid systems, units furnished should be specified in multiples of 10 pounds of liquid contents delivered, rounded up to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were actually delivered during the preceeding 30 day period, the unit entry "07" should be made. For units of portable contents only (i.e., no stationary gas or liquid system used) round up to the nearest five cubic feet or one liquid pound, respectively.

H. Oxygen Equipment and Contents Billing Chart.--The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios.

A. Situation: Bene Uses a Stationary System Only

1. Rental Cases

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes	No	No	No	N/A
Gaseous	Yes	No	No	No	N/A
Liquid	Yes	No	No	No	N/A

2. Purchase Cases

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes(installment)	No	No	No	Yes
Gaseous	Yes(installment)	Yes	No	No	Yes
Liquid	Yes(installment)	Yes	No	No	Yes

B. Situation: Bene Uses Both a Stationary and Portable System

1. Rents stationary/Rents portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes	No	Yes	No	N/A
Gaseous	Yes	No	Yes	No	N/A
Liquid	Yes	No	Yes	No	N/A

2. Rents stationary/Owns portable

Concentrator	Yes	No	Yes(installment)	No	No/Yes
Gaseous	Yes	No	Yes(installment)	No	No/Yes
Liquid	Yes	No	Yes(installment)	No	No/Yes

3. Owns stationary/Owns portable

Concentrator	Yes(installment)	No	Yes(installment)	Yes	Yes/Yes
Gaseous	Yes(installment)	Yes	Yes(installment)	No	Yes/Yes
Liquid	Yes(installment)	Yes	Yes(installment)	No	Yes/Yes

4. Owns stationary/Rents portable

Concentrator	Yes(installment)	No	Yes	Yes	Yes/No
Gaseous	Yes(installment)	Yes	Yes	No	Yes/No
Liquid	Yes(installment)	Yes	Yes	No	Yes/No

C. Situation: Bene Uses a Portable System Only

1. Rents portable system

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Gaseous	No	No	Yes	Yes	N/A
Liquid	No	No	Yes	Yes	N/A

2. Owns portable system

Gaseous	No	No	Yes(installment)	Yes	Yes
Liquid	No	No	Yes(installment)	Yes	Yes

The carrier considers the following when processing oxygen claims:

o Whenever the volume adjustment and the portable add-on both apply, it pays only the higher of the two;

o Does not make additional payments for either stationary or portable contents whenever a stationary system is rented. The monthly oxygen payment amount already includes reimbursement for all required contents;

o Makes payments for purchased oxygen equipment on an installment basis (equal to the fee for rental) until either medical necessity ends or, the fee schedule amount for purchase or, the actual purchase price is reached, whichever comes first; and

o The portable content fee is never payable in addition to the "regular" content fee. The regular content fee already includes portable content reimbursement.

I. Reporting Units of Service.--Report under Item 52 "Units of Service" on the HCFA-1450, the number of items being billed when billing the intermediary for orthotics and prosthetics.

J. Coordination with Carriers and Intermediaries.--The carrier furnishes you copies of fee schedules and updates for DME. Your intermediary furnishes you copies for orthotics and prothetics. The fee schedule amounts are adjusted periodically to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average.)

There may be DME procedures and orthotics and prosthetics for which you bill that are not included in the fee schedule. Where gaps occur, workout procedures with your carrier for DME and with your intermediary for the others, so that a fee schedule can be established. Codes which are assigned to fill gaps are valid until replaced by permanent codes in an annual update.

317. BILLING FOR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs) SERVICES

A. Administrative Services.--Certain services provided by the CORF are considered administrative services. Do not include these charges on the HCFA-1450. Their costs are included in the cost report and are also considered in the calculation of the interim rate paid by the intermediary for billable services.

Examples of administrative services are CORF physicians' services, team conferences, case reviews, plan of treatment review, and routine nursing services.

Refer to the Provider Reimbursement Manual for additional information.

NOTE: Physician's diagnostic and therapeutic services furnished to a CORF patient are not CORF physicians' services. The physician must bill the carrier for these services. (See §403.1.)

B. Patient Evaluation and Reevaluation.--

o If a patient receives an evaluation and there is no need for additional services, bill the evaluation as a visit.

o When an initial evaluation and treatment are rendered on the same day, do not bill for two visits. The usual charge for one visit can be increased to reflect the extra services.

o Perform a reevaluation during a regular treatment visit. Do not bill for it separately. The charge should reflect the reevaluation.

NOTE: Generally, you will use the zero level revenue code. The intermediary may require the specific code for evaluation/reevaluation if needed for bill review.

Refer to §318 for an all-inclusive list of revenue codes to use in billing CORF services.

C. Services Billed on the HCFA-1450.--Services that can be billed on the HCFA-1450 by a CORF are:

o Physical therapy, occupational therapy, speech pathology services and respiratory therapy. Includes patient evaluation, testing, treatment, and other services defined as covered therapy services. (See §§205.5, 205.6, and 403.2-403.5.)

o Social and psychological services. (See §§403.7, 403.8, and 405.)

o Nursing services. Billable services are identifiable rehabilitation services which a nurse is qualified to perform and which do not duplicate services performed by the therapist or other skilled nursing services specified in the plan of treatment. (See §403.9.)

o Prosthetic and orthotic devices, including testing, fitting, or training in the use of such devices. (See §403.6.)

o Drugs and biologicals which cannot be self administered. (See §403.10.)

o Supplies, appliances, and equipment including the purchase or rental of durable medical equipment (DME) from the CORF. (See §403.11.)

NOTE: Equipment and appliances used at the CORF are reimbursed as overhead costs.

o Home environment evaluation, (a single home visit to evaluate the potential impact of the home environment on the rehabilitation goals). Bill under line item or revenue code of the professional who made the visit.

o Certain diagnostic tests to be evaluated by a physician, such as pulmonary function, spirometry, and blood gas analysis are included under specific revenue codes.

D. Offsite CORF Services.--Effective with services furnished on and after December 22, 1987, CORFs may provide physical, speech and occupational therapy off the CORF's premises in addition to the home evaluation. (See §402.) Bill services provided offsite separately. Identify them as "offsite" in Remarks Item 94. Include in the charges for offsite visits any additional charge for providing the services at a place other than your premises. There is no change in the interim reimbursement method for offsite services.

E. Psychiatric Services Limitation.--The amount of a beneficiary's incurred psychiatric expenses that can be recognized in any calendar year is the lesser of 62 1/2 percent of expenses or the amount shown in the following table:

Year of Service	Limit Recognized	Payment Limit
Through 12/31/87	$ 312.50	$ 250.00
1/1/88 - 12/31/88	562.50	450.00
1/1/89 and after	1,375.00	1,100.00

Apply these limits to revenue code 910 on CORF claims.

Uniform Billing

318. COMPLETION OF FORM HCFA-1450 FOR BILLING CORF, OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR SPEECH PATHOLOGY SERVICES

The HCFA-1450 (also known as the UB-82) is a uniform institutional provider bill suitable for use in billing multiple third party payers. In addition, a number of data elements not required by Medicare but required by other payers are included. For Medicare billing, complete only the information required by Medicare. When billing multiple third parties complete all items required by each payer, and forward a copy to each.

Item 1. (Untitled) Provider Name, Address, and Telephone Number
The minimum entry is the facility's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (Item 7) to verify provider identity.

Item 2. Untitled
Not required. This is one of four fields on the form reserved for use within a State by the State Uniform Bill Committee, where one exists. Once such assignment is made within a State, that item may be used only for the designated purpose.

Item 3. Patient Control Number
Not required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

Item 4. Type of Bill
This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit-Type of Facility	
Clinic	7
2nd Digit-Bill Classification	
CORF and Outpatient (visit charges)	4

3rd Digit-Frequency	Definition
1-Admit Through Discharge Claim	Used for a bill encompassing an entire course of treatment for which the facility expects reimbursement from the payer.
2-Interim-First Claim	Used for the first of an expected series of payment bills for the same course of treatment.
3-Interim-Continuing Claim	Used when a payment bill for the same course of treatment has already been submitted and further bills are expected to be submitted at a later date.
4-Interim-Last Claim	Used for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (Item 22) is the discharge date for this episode of care.
5-Late Charges Only	Use for outpatient claims only.
6-Adjustment of Prior Claims	Use this code to show an increase and/or decrease in charges. You must obtain the intermediary's permission to use this code.
7-Replacement of Prior Claim	Used to correct a previously submitted bill. This is the code applied to the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	Indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.

Item 5. Blue Cross/Blue Shield Provider Number
Not required.

Item 6. Federal Tax Number
Not required.

Item 7. Medicare Provider Number
Enter the six-digit number assigned by Medicare.

Item 8. Medicaid Provider Number
Not required.

Item 9. Untitled
See Item 2 above.

Item 10. Patient Name
Enter the patient's last name, first name, and middle initial.

Item 11. Patient Address
Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP code.

Item 12. Birthdate
Enter the month, day, and year of birth (MM-DD-YY) of patient. If the full correct date is not known, leave blank.

Item 13. Sex
Enter the sex of the patient as recorded on the date care started. Use the following codes:

M=Male
F=Female

Item 14. Patient Marital Status
Not required.

Item 15. Admission Date
Not required.

Item 16. Admission Hour
Not required.

Item 17. Type of Admission
Not required.

Item 18. Source of Admission
Not required.

Item 19. Accident Hour
Not required.

Item 20. Discharge Hour
Not required.

Item 21. Patient Status
Enter the code indicating the patient's status as of the "Through date in item 22."

Code Structure

Discharged	01
Expired (or did not recover)	20
Still Patient	30

Item 22. Statement Covers Period
Enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or death in the space provided under "Through." Bills may not span two accounting years.

Item 23. Covered Days
Not required.

Item 24. Noncovered Days
Not required.

Item 25. Coinsurance Days
Not required.

Item 26. Lifetime Reserve Days
Not required.

Item 27. (Untitled)
See item 2 above.

Use of Occurrence and Occurrence Span Fields (Items 28-33, Below)

Due to the varied nature of occurrence and occurrence span codes, provisions have been made to allow the use of both type codes within each space. The occurrence span code can contain an occurrence code where the "Through" date would not contain an entry. This allows the use of as many as six occurrence codes.

When item 33 is utilized, items 31 and 32 may be utilized to contain the "From" and "Through" dates of an occurrence span code. In this case, the code in item 31 is the occurrence span code and the occurrence span "From" date is in the date field. Item 32 contains the same occurrence span code as the code in item 31 and the occurrence span "Through" date is in the date field.

This scheme necessitates that the occurrence and occurrence span codes be exclusive. Occurrence codes have values from 01 through 69 and occurrence span codes have values from 70 through 99.

Items 28, 29, 30, 31, and 32. Occurrence Codes and Dates
Enter the appropriate codes and dates from the table below where one or more occurrences are applicable. If there are more occurrences than there are spaces on the form, use item 33 (Occurrence Span) or item 94 (Remarks) to add additional occurrences and dates.

NOTE: Only Medicare requirements are included. Occurrence codes 01-03 and 24 are required only when claiming a conditional payment from Medicare. They must be accompanied by the entry of the appropriate value code in Items 46-49.

Code	Title	Definition
01	Auto Accident	Enter the date of an auto accident affecting this billing. Auto medical no-fault insurance involved. (See §332.)
02	Auto Accident/No-Fault Insurance Involved	Enter the date of an auto accident affecting this billing. Auto medical no-fault insurance involved. (See §332.)
03	Accident/Tort Liability	Enter the date of a nonautomobile accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party. (See §332.)
04	Accident/Employment Related	Enter the date of an accident affecting this billing which relates to the patient's employment. (See §335.)
05	Other Accident	Enter the date of an accident affecting this billing which is not described by any preceding occurrence codes.
11	Onset of Symptoms/Illness	Code indicates the date the patient first became aware of symptoms/illness.
18	Date of Retirement Patient/Beneficiary	Enter the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Enter the date of retirement for the patient's spouse.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
28	Date CORF Plan Established or Last Reviewed	Enter the date a plan of treatment was established or last reviewed for CORF care.
29	Date OPT Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for OPT.
30	Date Speech Pathology Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for speech pathology.

Code	Title	Definition
33	First Month of the 12 Month Coordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of the first month of the 12 month period during which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
35	Date Treatment Started	Enter the date the treatment began for any of the therapies.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the bill if more convenient for you.

Item 33. Occurrence Span Code and Dates
Not required.

Item 34. (Untitled except on Patient Copy of the bill) Responsible Party Name and Address

Not required. Space is provided for the use of a window envelope if you use the patient copy of the bill set. For claims which involve payers of higher priority than Medicare as defined in Item 65, enter the address of the other payer in Item 94 (Remarks).

Items 35, 36, 37, 38, 39. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect payer processing.

Code	Title	Definition
02	Condition is Employment Related	Enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment.
04	Patient is HMO Enrollee	Enter this code to indicate the patient is a member of a Health Maintenance Organization.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide you with information concerning other insurance coverage.
09	Neither Patient Nor Spouse is Employed	Enter this code to indicate that in response to development questions, the patient and spouse have denied any employment.

10	Patient and/or Spouse is Employed But No EGHP Coverage Exists	Enter this code to indicate that in response to development questions, the patient and spouse have indicated that they are employed but hold no group coverage from an EGHP.
11	Disabled Beneficiary, But No LGHP Coverage	Enter this code to indicate that in response to development questions, the disabled beneficiary and/or family member has no group coverage from a LGHP.
20	Beneficiary Requested Billing	Enter this code when you realize the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination of coverage by Medicare.
77	You Accept or are Obligated/ Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Enter this code to indicate that you have accepted or are obligated/required due to a contractual arrangement or law to accept payment as payment in full. Therefore, no Medicare payment is due. (See §§332-335.)
79	CORF Services Provided Off Site	Enter this code to indicate that physical therapy, occupational therapy, or speech pathology services were provided off site.

Item 40. Pints of Blood Furnished
Not required.

Item 41. Pints of Blood Replaced
Not required.

Item 42. Pints of Blood Not Replaced
Not required.

Item 43. Blood Deductible Pints
Not required.

Item 44. Special Program Indicator
The only special program indicator that applies to Medicare is:

Code	Title	Definition
06	PPV/Medicare 100-Percent Payment	Enter this code to show that pneumococcal pneumonia vaccine (PPV) will be reimbursed at 100 percent without deductible or coinsurance.

Item 45. Untitled
See Item 2, above.

Items 46, 47, 48, and 49. Value Codes and Amounts
Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two numeric digits, and each value allows up to eight numeric digits (000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, show codes in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use Items 46a through 49a before Items 46b through 49b (i.e., use the first line before the second line).

12	Working Aged Beneficiary/Spouse With EGHP	Indicates the amount shown is that portion of a higher priority EGHP insurance payment made on behalf of an aged beneficiary that applies to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. (See §334.)
13	ESRD Beneficiary in the 12 Month Coordination Period With An EGHP	Indicates the amount shown is that portion of a higher priority EGHP insurance payment made on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if claiming a conditional payment. (See §333.)
14	Automobile, No-Fault or Any Liability Insurance	Indicates the amount shown is that portion of a higher priority automobile, no-fault or liability insurance payment made on behalf of a Medicare beneficiary that your are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See §332.)

Code	Title	Definition
15	WC	Indicates the amount shown is that portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if claiming a conditional payment because there has been a substantial delay in the other insurer's payment. (See §335.)
16	PHS, Other Federal Agency	Indicates the amount shown is that portion of a higher priority PHS or other Federal agency's payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill.
41	BL	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges on this bill. Enter six zeros (000000) in the amount field, if you are claiming a conditional payment because there has been a substantial delay in payment. (See §245.)
42	VA	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges on this bill. (See §233.4.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGPH payment made on behalf of a disabled beneficiary that you are applying to Medicare charges on this bill.

50	Physical Therapy Visit	Code indicates the number of physical therapy visits from onset (at the billing provider) through this billing period.

NOTE: This is not a money, but a number of visits value. Enter for the number of visits right justified from the dollars/cents delimeter as follows:

				1	3		

Item 50. Revenue Description
Enter a narrative description or standard abbreviation for each revenue code shown in column 51 on the adjacent line in column 50. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown in Item 51, below.

When using this form for DME billing, identify the specific piece of DME on the line adjacent to revenue codes 291, 292, or 293, as appropriate. This description may be narrative or, if preferred by your intermediary, HCPCS (HCFA Common Procedure Coding System) codes. If HCPCS is required by your intermediary, it supplies you with an appropriate list.

Item 51. Revenue Code
Enter the appropriate revenue codes from the list below to identify specific charges. Enter the appropriate three-digit numeric revenue code on the adjacent line in column 51 to explain each charge in column 53. This data takes the place of fixed line item descriptions on the billing form. See Addendum C for additional revenue code breakdown.

Additionally, there is no fixed "Total" line in the charge area. Enter, instead, revenue code "001" in column 51. Thus, the adjacent charge entry in column 53 is the sum of charges billed. This is also the same line on which charges, if any, in columns 54-56 are summed.

To assist in bill review, list revenue codes in ascending numerical sequence to the extent possible. Do not repeat revenue codes on the same bill. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Detailed level of coding is always required when using the 29X revenue code series.

Use the following revenue codes to bill Medicare for CORF services.

Description	Code
Drugs and Biologicals	250
Supplies	270

Description	Code
Prosthetic Devices	274
Orthotic Devices	279
Rental of DME	291
Purchase of New DME	292
Purchase of Used DME	293
Respiratory Therapy Services	410
Home Evaluation Visit	419
Physical Therapy Services	420
Home Evaluation Visit	429
Occupational Therapy Services	430
Home Evaluation Visit	439
Speech Pathology Services	440
Home Evaluation Visit	449
Pulmonary Function	460
Audiology	470
Stress Test	482
Nursing Services	550
Home Evaluation Visit	559

Description	Code
Social Services	560
Home Evaluation Visit	569
EKG, ECG	730
Psychological Services	910
Diagnostic Testing (initial psychological)	918
Home Evaluation Visit	919
EMG	922
Other Diagnostic Services (Specify)	929

Use these revenue codes when billing for outpatient therapies.

Physical Therapy	420
Occupational Therapy	430
Speech Pathology	440

Item 52. Units of Service
Enter the number of visits or units of service on the line adjacent to revenue code and description where appropriate. Provide the number of units or visits as applicable.

Always show visits for revenue codes 41X, 42X, 43X, 44X, 55X, 56X and 91X.

Enter up to three numeric digits.

Show zero level revenue codes for all services except stress test, EMG, diagnostic testing, other diagnostic services and home evaluation visits.

Item 53. Total Charges
Sum the total charges for the billing period by revenue code (column 51) and enter them on the adjacent line in column 53. The last revenue code entered in column 51 is "001" which represents the total of all charges billed. Sum column 53 on the adjacent line. Each line allows up to eight numeric digits (000000.00).

Items 54, 55, and 56. Unlabeled Charge Columns
Not required.

Items 57A, B, C. Payer Identification
If Medicare is the primary payer, enter "Medicare" on line A. All additional entries across line A (items 58-64) supply information needed by the payer named in item 57A. If Medicare is the secondary or tertiary payer, make the appropriate entries on lines B or C, respectively. (See §§332, 333, 334, and 335 to determine when Medicare is not the primary payer.)

Items 58A, B, C. Release of Information Certification Indicator
Not Required.

NOTE: The back of the UB-82 contains your certification that all necessary release statements are on file.

Items 59A, B, C. Assignment of Benefits Certification Indicator
Not Required.

Items 60A, B, C. Deductible
Not required for services rendered April 1, 1985, and later.

NOTE: Effective with services rendered April 1, 1985, and later, amounts collected from the patient toward the Part B cash deductible are not reported in this item, but are reported on the fourth line of Item 63. Such amounts may only be reported on bills containing "4" in the second position of Item 4, Type of Bill.

Items 61A, B, C. Coinsurance
Not required for services rendered April 1, 1985, and later.

NOTE: Effective with services rendered April 1, 1985, and later, amounts collected from the patient toward Part A cost sharing for DME ("3" in the second position of Item 4, Type of Bill and revenue code(s) in the 29X series entered in Item 51) or toward Part B coinsurance ("4" in the second position of Item 4, Type of Bill) are reported on the fourth line of Item 63.

Item 62A, B, C. Estimated Responsibility
Not Required.

Items 63A, B, C. Prior Payments
For services rendered April 1, 1985, and later, enter on the unnumbered (fourth/last) line of this column the sum of any amount(s) collected from the patient toward:

o Cost sharing for Part A DME ("3" in second position of Item 4, Type of Bill and revenue code(s) in 29X series in Item 51), or

o Part B cash deductible and/or coinsurance for services rendered which are not under a plan of treatment ("4" in second position of Item 4, Type of Bill).

Items 64A, B, C. Estimated Amount Due
Not Required.

Items 65A, B, C. Insured's Name
Required. On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in Items 57-63, enter the patient's name as shown on his HI card or other Medicare notice.

Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and you are requesting payment because:

o Another payer paid some of the charges and Medicare is secondarily liable for the remainder;

o Another payer denied the claim; or

- You are requesting conditional payment as described in §§332D, 333D, 334D, or 335D.

If that person is the patient, enter "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and spouses age 65 or over;
- EGHPs for beneficiaries entitled to benefits soley on the basis of ESRD during a period of up to 12 months;
- LGHPs for disabled beneficiaries;
- An auto-medical, no-fault, or liability insurer; or
- WC including BL.

Items 66A, B, C. Insured's Sex
If claiming a conditional payment under any of the circumstances described under items 65A, B or C above, enter the sex of the insured. Use the following codes:

M=Male
F=Female

Items 67A, B, C. Patient's Relationship To Insured
If claiming a payment under any of the circumstances described under items 65A, B or C above, enter the code indicating the relationship of the patient to the identified insured.

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
15	Injured Plantiff	Patient is claiming insurance as a result of injury covered by insured.

Items 68A, B, C. Certificate/Social Security Number/Health Insurance Claim/Identification Number
On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in items 57-63, enter the patient's Medicare HICN; i.e., if Medicare is the primary payer, enter this information in item 68A. Show the number as it appears on the patient's Health Insurance Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the SSO.

If claiming a conditional payment under any of the circumstances described under items 65A, B or C above, enter the involved claim number for that coverage on the appropriate line.

Items 69A, B, C. Group Name
When claiming a payment because a higher priority EGHP has denied or has not paid yet for a first year ESRD beneficiary or has denied a working aged beneficiary, enter the name of the group or plan through which that insurance is provided.

Items 70A, B, C. Insurance Group Number
When claiming a payment under the circumstances described under items 65A, B or C above, enter the identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

GUIDELINES FOR EMPLOYMENT INFORMATION

The following five items are grouped together for ease in transmitting instructions on their completion: 71, 72, 73, 74, 75. Space is reserved for reporting the necessary employment data for up to two individuals. Use the following sequence of decision-making in completion of these fields.

INDIVIDUALS CLAIMING INSURANCE

- If any of the insureds named under A, B or C in the insurance section of the form (item 65) has group insurance provided by an organization other than the employer, enter the insured's employment information and the EID (item 71) coded A, B or C depending upon the payer line the individual's insurance information is recorded. (For example, item 69 records Group Name as Washington Area Ford Dealers, Inc. but the insured's employer is Capital Ford, Inc. Because the insurance is held with a company other than the employer, the employer information is required for the insured.)

- o If any of the individuals recorded under A, B or C in the insurance section of the form (item 65) has group insurance coverage provided by an employer who operates from multiple locations, enter employment information (and location) and the EID (item 71) coded A, B or C depending upon the payer line the individual insurance information is recorded.

Item 71. Employment Information Data
Where you are claiming a conditional payment under the circumstances described under items 65A, B or C and there is involvement of WC or an EGHP, enter the code that indicates whether the employment information given on the same line in items 72-75 applies to the insured, the patient or the patient's spouse.

Use either the "A, B, C" codes or the "P, S, F, M" codes, in this item, depending upon which set best handles the billing situation.

Code Structure

A = Employment Information relates to primary insured.
B = Employment Information relates to secondary insured.
C = Employment Information relates to tertiary insured.
P = Patient Employment Information
S = Spouse Employment Information
F = Father's Employment Information
M = Mother's Employment Information

NOTE: When there is a single employer, enter only one code from the code structure. When the employment information pertains to multiple payers from Item 57, enter two codes.

Item 72. Employment Status Code
Where you are claiming a payment under the circumstances described under Items 69A, B, or C and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified on the same line in Item 71, if the information is readily available.

Code	Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.

Item 73. Employer Name
Where you are claiming a payment under the circumstances described under Items 69A, B, or C and there is involvement of WC or an EGHP, enter the name of the employer that provides health care coverage for the individual identified on the same line in Item 71.

Item 74. Employee Identification Number
Where you are claiming a payment under the circumstances described under Items 69A, B, or C and there is involvement of WC or EGHP, enter the identification number assigned by the employer to the individual identified on the same line in Item 71.

Item 75. Employer Location
Where you are claiming a payment under the circumstances described under Items 69A, B, or C and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual identified on the same line in Item 71. A specific location is the city, plant, etc. in which the employer is located.

Item 76. Principal and Other Diagnoses Descriptions
Not required.

Item 77. Principal Diagnosis Code
Report the principal diagnosis or diagnosis most closely related to the plan of treatment,

according to the attending physician, in this item. Report the full ICD-9-CM diagnosis code, including all five digit codes where applicable.

Items 78-81. Other Diagnoses Codes
Enter the ICD-9-CM codes for up to four additional diagnoses for conditions coexisting according to the attending physician.

Item 82. Procedure Coding Method Used
Not required.

Item 83. Principal and Other Procedures Descriptions
Not required.

Item 84. Principal Procedure Code and Date
Not required.

Item 85 and 86. Other Procedure Codes and Dates
Not required.

Item 87. PRO/UR Approval Indicator
Not required.

Item 88 and 89. PRO/UR Approved Stay Dates
Not required.

Item 90. Number of Grace Days
Not required.

Item 91. Treatment Authorization Code
Not required.

Item 92. Attending Physician I.D.
Not required.

Item 93. Other Physician I.D.
Not required.

Item 94. Remarks
Enter special annotations where Medicare is not the primary payer because WC, automobile medical, no-fault, liability, or an EGHP is primary to Medicare. (See §§332, 333, 334 and 335 for appropriate annotations.)

If the services you provided are offsite, enter statement "Offsite Services." In addition, enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date
Make sure that the required physician's certification is in the records before signing the form. A stamped signature is acceptable.

Intermediary Use Only Area.
Not Required.

319. SUBMITTING CORRECTED BILLS

Submit a corrected HCFA-1450 if any of the following apply:

- A change in provider number;
- A change in co-insurance involves an amount greater than $1.99; or
- A change in visits (decrease or increase).

To correct a previously submitted bill, reproduce a legible copy of the original. In Item 4, type of bill, third position, use frequency code 8 (void/cancel of prior claim). Prepare a new bill using frequency code 7 (replacement of prior claim). Annotate Item 94 "Remarks" with a brief explanation. Send the bills to your intermediary or HMO as appropriate.

Where there are money adjustments other than a co-insurance amount greater than $1.99, record the difference on a record sufficiently documented to establish an accounting data trail, including patient's name and HICN, first and last dates of service, and any unique numbering or filing code necessary to associate the adjustment charge with the original billing.

320. HEALTH INSURANCE CLAIM FORM (HCFA-1500) FOR OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR SPEECH PATHOLOGY SERVICES BY CLINICS

Submit the HCFA-1500 to the carrier. Outpatient physical therapy, occupational therapy or speech pathology you furnished before the effective date of your certification can be covered only if furnished by a physician or if incident to a physician's services.

NOTE: If the patient is a railroad annuitant, the carrier transfers the claim to the railroad carrier (The Travelers Insurance Company) for processing. The Travelers Insurance Company sends the notice of benefits and other information you require directly to you.

List charges for outpatient physical therapy, occupational therapy, or speech pathology services on a separate HCFA-1500. Any charge for other clinic services requires the completion of another HCFA-1500.

320.1 When to Submit Billing Form for Outpatient Physical Therapy, Occupational Therapy or Speech Pathology Services.--Submit a HCFA-1500 to the carrier when you furnished outpatient physical therapy, occupational therapy or speech pathology services. Do not submit the HCFA-1500, however, if the patient is not enrolled under Part B or if WC will pay the bill.

320.2 How to Complete the HCFA-1500 Health Insurance Claim Form.--

ITEM 1. PATIENT'S NAME.
Enter the patient's first name, middle initial, if any, and last name from his Medicare card.

ITEM 2. PATIENT'S DATE OF BIRTH.
Enter the patient's date of birth.

ITEM 4. PATIENT'S ADDRESS.
Enter the patient's complete mailing address, i.e., number, street, city, State, and ZIP code. If a box number or "in care of" is in the address, include it. (Show in Item 21 the name and address of the SNF, nursing home, or hospital where a patient received services.

ITEM 5. PATIENT'S SEX.
Check the correct sex designation.

ITEM 6. INSURED'S I.D., MEDICARE AND/OR MEDICAID NO.
Enter the patient's complete HICN as it appears on his Medicare card.

ITEM 9. OTHER HEALTH INSURANCE COVERAGE.
If the patient has other health insurance besides Medicare (e.g., private supplementary insurance, Medicaid, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), enter the name of the insuring organization and, the policy or medical assistance number.

ITEM 10. WAS CONDITION RELATED TO.
A. Complete this item to show whether the patient's condition is employment related.

B. Check the appropriate box if the condition resulted from an accident.

ITEM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.
The patient or his authorized representative must sign in this block. If the patient's representative signs, indicate the relationship to the patient. The signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the physician, if the physician accepts assignment.

Signature by Mark.—Where an illiterate or physically handicapped enrollee signs by mark (X), a witness signs his name and enters his address next to the mark.

ITEM 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE.
If the patient was referred to you, show the complete name of the referring source. Otherwise, leave blank. If this information was submitted on a previous bill, this item does not have to be completed.

ITEM 21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED.
If services were rendered somewhere other than at the address shown in item 31, indicate the name and address of the person or organization performing the service.

ITEM 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE.
Not applicable for physical therapy, occupational therapy or speech pathology services.

ITEM 23A. NATURE OF ILLNESS.
Enter the nature of the illness or injury in standard nomenclature.

ITEM 24A. DATE OF EACH SERVICE.
Show each date of service. Inclusive dates can be used where the same service and charge applies through the inclusive period. Because of the deductible provision described in §210, inclusive dates should not overlap December and January or periods when the patient was not entitled. Also, inclusive dates should not overlap the period before you were certified as a provider.

ITEM 24B. PLACE OF SERVICE.
Show only the alphabetic codes shown in parentheses on the back of the form. If the physician is billing for lab service performed in his own office, use code "O" (Doctor's Office). If the physician is billing for a lab service purchased from another physician who maintains a lab in his office, show code "OL" (Other Location). If the physician is billing for a lab service purchased from an independent lab, use code "IL" (Independent Laboratory). Complete items 21 and 22 for all laboratory work performed outside of the physicians office. Claim ambulance service (code 9) for Medicare beneficiaries on form HCFA-1491. Alpha codes "RTC" and "STF" are not used for Medicare.

ITEM 24C. DESCRIPTION OF SERVICE.
Furnish a precise description, in standard nomenclature, of the service being billed. Outpatient physical therapy, occupational therapy or speech pathology charges do not combine with the charges for any other type of service. Indicate the type of therapy furnished.

ITEM 24E. CHARGES.
Enter the charge for each service. If there were any special circumstances explaining the charge, describe these in 24C.

ITEM 25. SIGNATURE.
The physician or supplier or the authorized representative must sign the physician's or supplier's name in item 25. Provide the month, day, and year the form was signed.

Item 26. Assignment
Complete this item if the physician/supplier accepts assignment.

Items 27, 28, 29. Total Charges, Amount Paid, and Any Unpaid Balance Due
Enter any payments which the patient has made in Item 28. If the patient's payments exceed his liability, the carrier refunds the overpayment to the patient and deducts the overpayment from any amount otherwise due you.

Item 31. Physician's or Supplier's Name, Address, ZIP Code, and Telephone Number
Enter the name, complete mailing address, ZIP code, and telephone number. Include the physician's or supplier's SSN or EIN.

Request for Payment

321. FILING A REQUEST FOR PAYMENT

Medicare payment of reasonable cost may not be made for OPT, occupational therapy, speech pathology and CORF services, furnished under Part B by a rehabilitation center, public health agency, or clinic unless the beneficiary or his representative files a timely written request for payment and the provider files a timely claim.

321.1 Billing Forms as Request for Payment.--Each billing Form HCFA-1450 and HCFA-1500, contains a signature line incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, it must be signed. Forward the request for payment to the intermediary or carrier.

A single signed request suffices for each plan. However, a subsequent signed request for payment is required if there is a transfer of the patient's care from one clinic or agency to another.

321.2 Request for Payment on Provider Record.--In place of signatures on billing forms, you may use a procedure whereby the signature of the patient (or his representative, see §322) on your records serves as the request for payment for your services, for physician services which you are authorized to bill or for any other physician services you furnished as the provider. In the case of physician services, claims may be submitted on either an assigned or unassigned basis.

To implement the procedure, you must incorporate the following language in your records:

Statement to Permit Payment
of Medicare Benefits to Provider,
Physicians and Patient

NAME OF BENEFICIARY HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me, or on my behalf, for any services furnished me by or in (your name), including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

The request is effective until revoked. If a patient objects to part of the request for payment, annotate the statement accordingly and notify any physician affected.

If submitting claims under this procedure, indicate on the claim form that you have obtained the patient's signature by checking the block "Signature contained in the provider record," or, if the form does not contain such a block, by entering "Patient's request for payment in file" on the patient's signature line of the claim. A physician or medical group submitting claims under this procedures indicates that the provider has obtained the patient's signature by entering on the patient signature line of the claim, "Patient's request for payment on file in (name of provider)."

In using this procedure, you, the physician, or medical group must:

o Complete and submit promptly the appropriate Medicare billing form whenever services are provided to a Medicare beneficiary, even when assignment is not accepted for the physician services.

o Incorporate, by stamp or otherwise, information to the following effect on any bills sent to Medicare patients: "Do not use this bill for claiming Medicare benefits. A claim has been, or will be, submitted to Medicare on your behalf." This is necessary to prevent patients from submitting duplicate claims.

Make the patient signature files available for carrier and intermediary inspection upon request.

In the case of clinics, the carrier makes periodic audits of signature files selected on a random basis. In the case of rehabilitation agencies or public health agencies, such audits are made by the intermediary and, if physician services are covered by the signatures, by the carrier as well. However, the carrier may arrange with the intermediary for the latter to perform this function on its behalf.

321.3 Time Limitation on Filing Claims for OPT, Occupational Therapy, Speech Pathology, and CORF Services.--The beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished. For example, a claim for services rendered September 30, 1987, must be filed by December 31, 1988. A claim for services rendered October 1, 1987, must be filed by December 31, 1989.

No reimbursement can be made for claims filed after the time limitation except under the following conditions:

o Where failure to file a timely claim was due to SSA, HCFA, carrier or intermediary error, the time will be extended through the last day of the sixth calendar month after the month in which the error is rectified but not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

- o The time limit is extended to the next workday if it falls on a day which is not a Federal workday (e.g., Saturday, Sunday, legal holiday).

When bills are not filed timely, they will be denied; however, they should be filed and processed.

If an error of the SSA or its agents or the patient caused the bill to be filed late, attach to the bill a statement outlining the facts.

When the intermediary or SSA determines that the late filing was the patient's fault, the patient is responsible for the bill; if you are at fault in not filing a timely bill, you can bill the patient only for the deductible and coinsurance amounts.

The intermediary submits to the SSA any claim in which delay in establishing HI or SMI entitlement or notifying an individual of HI or SMI entitlement prevented the filing of a claim until more than 3 years after the year in which the services were furnished (fourth year after the year, in the case of services furnished in the last quarter of the year).

321.4 Time Limit for Filing Part B Reasonable Charge Claims.--For Medicare payment to be made for a claim for physician and other Part B services reimbursable on a reasonable charge basis (including services for which the charge is related to cost) the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered.

322. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the patient should sign the request at the time OPT, occupational therapy, speech pathology, or CORF services begin.

In certain circumstances, this is impracticable; for example, when the individual is incompetent or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the SSA to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at the time of the start of services, sign on his behalf.

323. REFUNDS

In its agreement for participation, the clinic, rehabilitation agency, or public health agency has agreed not to charge any individual or other person (e.g., relatives, other insurance carriers, or welfare) for items and services covered by the health insurance program other than allowable charges, deductibles, and coinsurance amounts; and to make provision for the refund (or other required disposition) of any moneys incorrectly collected from the individual or other person on his behalf.

Amounts incorrectly collected and not refunded represent improper charges for covered services under the provisions of §1866(a)(1) of the Act, and for any facility to retain these moneys and not make provision for refund (or other required disposition) constitutes a violation of its provider agreement.

A. Moneys Incorrectly Collected.—This means amounts in excess of allowable charges and the deductible and coinsurance, if applicable, paid to an OPT, speech pathology, occupational therapy, or CORF provider by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the Medicare program.

B. A Majority of Incorrect Collections.—These are made inadvertently and may involve a simple error on the part of the provider in billing a beneficiary. However, there are other situations where incorrect collection may be made. For example:

- In a retroactive entitlement case, where the beneficiary (or other person) paid for covered services and later becomes entitled to have payment made for them under Medicare;

- Where an intermediary (carrier) has initially denied payment and a subsequent finding is made (e.g., as the result of a reconsideration or hearing decision) that payment for all or part of the services may be made; and

- Where the beneficiary or other person has protested a direct charge by a provider and the intermediary determines that the beneficiary is entitled to have program payment made on his behalf for all or part of the services.

Intermediaries (carriers) will assure that you refund moneys incorrectly collected. Therefore, in the situations described above (and other similar situations recognized by the intermediary), the intermediary (carrier) will ascertain, on an individual case basis, whether you have received reimbursement for covered services from the individual or other person (e.g., relatives, other insurance carriers, or welfare) before making Medicare payment. If you advise, in writing, that you have not been reimbursed by the individual or other person for covered services, payment can be made.

If you have been reimbursed in whole or in part, the intermediary (carrier) withholds an amount equal to the incorrect collection from amounts otherwise due you until it is assured in writing by you that a proper disposition of the incorrect collection has been made.

Where the intermediary (carrier) knows that a provider has overcollected deductible and coinsurance amounts for OPT, speech pathology, occupational therapy, or CORF services, direct refund will be made to the beneficiary.

323.1 Return or Other Disposition of Moneys Incorrectly Collected.--An OPT, speech pathology, occupational therapy, or CORF provider in possession of any incorrect collection is required to refund or make final disposition of the money in accordance with applicable State law. If refund or final disposition will be delayed for a prolonged period, you are required to set aside the money in a separate account until the refund or final disposition is made. Until you advise, in writing, that you have properly refunded or disposed of the money or, as necessary, set it aside, the intermediary will withhold an amount equal to such incorrect collection against amounts otherwise due you.

A. Refund.--Refund to the beneficiary (or any other person) from whom you collected the moneys. If the beneficiary or other person cannot be located after you have made a reasonable effort including a mail contact at the last known address, asked your intermediary to check SSA's records in an effort to learn the individual's address. If the individual to whom the refund is to be made cannot be located or has died, make final disposition of the moneys in accordance with the law of the State in which you are located.

B. Moneys Set Aside.--In some situations refund or final disposition may be delayed for a prolonged period (e.g., where the beneficiary's whereabouts is being developed or where there is a delay in the appointment of a legal representative to dispose of the estate). When such a delay in making refund or final disposition is encountered, notify the intermediary and set the funds aside in a separate account identified by the name of the individual to whom the payment is due. Carry the amount on your records in this manner until refund or final disposition, as provided in subsection A is made.

323.2 Appropriate Time Limits Within Which Provider Must Dispose of Sums Incorrectly Collected.--Refund or final disposition in accordance with applicable State law of sums incorrectly collected must be accomplished as promptly as possible. In any event, refund, final disposition, or as necessary, setting funds aside in a separate account must be accomplished within 60 days after you are notified that an incorrect collection was made.

323.3 Former Participating OPT, Speech Pathology, Occupational Therapy, or CORF Providers.--Once an OPT, speech pathology, occupational therapy, or CORF provider has become a participating provider, it remains responsible notwithstanding the subsequent termination of its program participation for the required refund or final disposition of any moneys incorrectly collected for covered services furnished to Medicare beneficiaries during the effective period of its provider agreement.

Retention and Destruction of Health Insurance Records

330. RETENTION OF HEALTH INSURANCE RECORDS

Maintain health insurance materials related to services rendered under title XVIII for the prescribed retention periods outlined below unless State law stipulates a longer period. They must be available for review by HCFA, intermediary, DHHS audit, or other specially designated components for bill review, audit, and other references during the retention period.

A. Categories of Health Insurance Records to Retain.--If these records are microfilmed, also see subsection C.

o Billing Material.--CORF, OPT, occupational therapy or speech pathology provider copies of forms HCFA-1450 or HCFA-1500, supporting documents and forms, charge slips, and other business and accounting records referring to specific claims.

o Cost Report Material.--All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, cancelled checks, CORF, OPT, occupational therapy or speech pathology provider copies of material used in preparing the annual cost report, and other similar cost reports of dealings with outside sources of medical supplies and services or with related organizations.

B. Retention Period for Health Insurance Records.--Retain all materials for 5 years after the month the cost report to which the materials apply is filed.

EXAMPLE: Billing materials support claims filed during a cost report period ending 10/31/86. The CORF's, OPT, occupational therapy or speech pathology provider cost report for the period ending 10/31/86, was filed with the intermediary on 1/15/87. Retain all billing materials until 2/1/92.

After payment of the bill, the CORF, OPT, occupational therapy or speech pathology provider need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in subsection A. These records, punch cards, adding machine tapes, internal controls, or other similar material are not required for period retention.

C. Microfilming Health Insurance Records.--A CORF, OPT, occupational therapy or speech pathology provider may microfilm all health insurance records.

- Billing material (Forms HCFA-1450 or HCFA-1500) with any attachments that the CORF, OPT, occupational therapy or speech pathology provider has furnished to its intermediary may be destroyed providing the microfilm accurately reproduces all original documents.

- Retain copies of all other categories of health insurance records listed in subsection A in their original form. If a CORF, OPT, occupational therapy or speech pathology provider microfilms these records, store them in a low cost facility for the retention period.

330.1 Destruction of Health Insurance Records.--When material no longer needs to be retained for title XVIII purposes, it may be destroyed unless State law stipulates a longer period of retention.

To insure the confidentiality of the records, destroy them by shredding, mutilation, or other protective measures. The method of final disposition of the records may provide for their sale or salvage. Report moneys received as an adjustment to expense in the cost report for the year sold.

Billing where Medicare is Secondary Payer

332. BILL PREPARATON WHERE SERVICES ARE REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO-FAULT INSURANCE, OR ANY LIABILITY INSURANCE

A. General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under automobile medical or no-fault insurance. In the case of liability insurance, primary Medicare benefits are paid conditionally and then recovered. For an explanation of these provisions see §247 for automobile medical and no-fault insurance and §248 for liability insurance.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward the Part B deductible amount.

Where Medicare is determined to be the primary payer, show Medicare on line A of Item 57. Where Medicare is secondary, show Medicare on line B of Item 57. Where Medicare is not the primary payer because of automobile medical or no-fault insurance, prepare the bill in accordance with the following instructions. It may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). (See §336.) Where a liability insurer is involved, follow the guidelines in subsection E.

B. Outpatient Bills - Full Payment by Automobile Medical or No-Fault Insurance.—If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by subsection C) equals or exceeds your charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance), or you accept, or are obligated to accept, the payment as payment in full, do not submit a bill.

C. Outpatient Bills - Partial Payment by Automobile Medical or No-Fault Insurance.—If payment from the automobile medical or no-fault, insurer for Medicare covered services (as determined by the following formula) is less than your charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance), and you do not accept, and are not obligated to accept, the payment as payment in full, prepare the bill in accordance with §318 with the following modifications:

Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the automobile medical or no-fault insurer's payment.

Determining amount of primary payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate that amount in value codes (Items 46-49). Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services. Indicate this amount in value codes (Items 46-49). You must be able to validate your ratio of covered and noncovered charges, if requeted.

EXAMPLE:

Total charges were $200. Medicare covered charges were $180. The automobile medical insurer's payment was $55. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$180}{\$200} \text{ X } \$55 = \$50$$

Show $50 in value codes (Items 46-49).

Determining the amount of Medicare payment

Subtract the payment by the automobile medical, or no-fault insurer for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §336. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1: Percentage of Billed Charges

Outpatient care was furnished to a Medicare beneficiary whose automobile medical insurer was the primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met. The automobile medical insurer paid $50 for Medicare covered services as determined above. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges is $162. Calculate the deductible and coinsurance as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $162 - $50 = $112 which exceeds $75. The Part B deductible amount you can charge the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 X 20 percent = $11 coinsurance.

As secondary payer, Medicare pays: the Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the deductible and coinsurance: $162 - $50 - $75 - $11 = $26. Medicare pays $26.

EXAMPLE 2: Percentage of Billed Charges

Same facts as above except the covered charges were $100, the primary payer's payment is $60 and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges is $90. Calculate the deductible and coinsurance as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $90 - $60 = $30. Since $30 is less than $75, the Part B deductible amount you can charge the beneficiary is $30.

Since the $75 Part B deductible is not met, there is no coinsurance amount and there is no Medicare payment. The patient's liability is $30 of the $75 deductible.

EXAMPLE 3: Per Visit Method

A beneficiary received 8 visits for which you billed $180.00. No part of the beneficiary's Part B deductible had been met. The automobile medical insurer paid $50 for Medicare covered services as determined above. The current Medicare interim reimbursement amount at $20 per visit rate is $160.00. The deductible and coinsurance are as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $160 - $50 = $110 which exceeds $75. The Part B deductible amount charged the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 x 20 percent = $11 coinsurance.

As secondary payer, Medicare pays the following: the Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the deductible and coinsurance: $160 - $50 - $75 - $11 = $24. Medicare pays $24.

Special entries on the bill

Show the identifying information in Items 57-68 on the first payer line, occurrence code 01, or 02, as appropriate and the associated date in Items 28-32, value code 14 with the amount paid in value codes (Items 46-49), and the address of the automobile medical or no-fault insurer, in Item 34 or Remarks (Item 94).

D. Automobile Medical or No-Fault, Insurer Does Not Make Payment.--If services are related to an automobile accident and an automobile insurer has been billed but does not make payment, e.g., the services are not covered under automobile medical or no-fault insurance or the individual's insurance coverage expired, bill Medicare as usual. In addition, show the proper occurence code as indicated below in Items 28-32. Complete occurrence code 24 to show the date the other payer denied the claim and enter the reason for the denial in Remarks (Item 94.)

01—auto accident
02—auto accident, no-fault insurance

If the claim is contested by an automobile medical or no-fault insurer or for any other reason there will be a substantial delay, request conditional primary benefits. Complete Items 46-49 (value codes) with value code 14 and zero value to indicate the type of other insurer and that conditional payment is requested. Identify the other payer on line A of Item 57, and enter on line A of Items 65-68 other identifying information about the insured. Enter the proper occurrence code as shown above in Items 28-32 and the address of the automobile medical, no-fault, or liability insurer in Item 34 or Remarks (Item 94). Explain why the conditional payment is justified in Remarks (Item 94).

E. Conditional Liability Claims.--If the services are related to an accident and there are no potential primary payers other than a liability insurer, bill Medicare for conditional primary payments. Bill Medicare even if you believe that there is a reasonable likelihood that the liability insurer will pay promptly. Complete the claim in accordance with the second paragraph of subsection D. In addition, enter occurrence code 03 in Items 28-32. (See §§248ff. for an explanation of policy and procedures for liability claims.)

333. MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS WHEN INDIVIDUALS ARE ENTITLED TO BENEFITS SOLELY ON THE BASIS OF ESRD

A. General.—Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals who are entitled to benefits solely on the basis of ESRD, during a period of up to 12 months.

Payment made by the ESRD-EGHP are used to satisfy the unmet deductible and the individual's coinsurance.

Where Medicare is determined to be the primary payer, show Medicare on line A of Item 57. Where Medicare is secondary, show Medicare on line B of Item 57. In addition, when billing Medicare because the ESRD-EGHP denied payment, enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). Enter the reason for the denial in remarks (Item 94). Where Medicare is not the primary payer because of coverage of an ESRD beneficiary by an EGHP, prepare the bill in accordance with the following instructions. It may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). Follow §336 to determine this amount.

B. Outpatient Bills - Full Payment by ESRD-EGHP.—If an ESRD-EGHP payment for Medicare covered services (as determined by subsection C below) equals or exceeds your charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance), or you accept, or are obligated to accept, the ESRD-EGHP payment as payment in full, and you know the individual has met his deductible, do not submit a bill.

However, submit a bill to inform the intermediary of charges where the deductible may not be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. Complete the bill in the usual manner. In addition:

o Determine the charges as usual, including those covered by the ESRD-EGHP payment. Your intermediary treats the charges shown in total charges as noncovered for reimbursement purposes but credits the deductible based upon the bill.

o Enter the amount paid by the ESRD-EGHP for Medicare covered services in Items 46-49 (value codes).

o Enter occurrence code 33 and the first month of the 12-month period in Items 28-32; and

o Enter condition code 77 in Items 35-39 when you accept or are obligated to accept the ESRD-EGHP payment as payment in full.

C. Outpatient Bills - Partial Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined below) is less than your charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance), and you do not accept, and are not obligated to accept, the ESRD-EGHP payment as payment in full, prepare the bill in accordance with §318 with the following modifications:

o Determining covered charges.

o Show in the covered charges column, Medicare covered charges including those covered by the ESRD-EGHP's payment.

o Determining amount of primary payment that applies to Medicare covered services.

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate that amount in value codes (Items 46-49). Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (Items 46-49). You must be able to validate your ratio of covered and noncovered charges, if requested.

EXAMPLE: Total charges were \$110. Medicare covered charges were \$90. The ESRD-EGHP payment was \$88. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$\ 90}{\$110} \times \$88 = \$72$$

Show \$72 in value codes (Items 46-49).

Determining the amount of Medicare payment.

The Medicare payment is the lower of:

o The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §336 minus the amount paid by the ESRD-EGHP for Medicare covered services; or

o The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §336 minus any applicable deductible or coinsurance amount.

That portion of the total charges equal to the ESRD-EGHP payment is credited toward any unmet deductible.

NOTE: Examples 1 thru 4 are based upon a percentage of billed charges

EXAMPLE 1: ESRD-EGHP payment less than unmet deductible

Outpatient services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met. The ESRD-EGHP paid $72 for Medicare covered services.

The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) for these services at 90 percent of charges would be $81. As secondary payer, Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) minus the ESRD-EGHP payment: $81 -$72 = $9.

- The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $75 -$3* = $3.

*Calculate the coinsurance as follows:

$90 charges - $75 deductible - $15 X 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the ESRD-EGHP payment and $3 by the beneficiary.

EXAMPLE 2: ESRD-EGHP payment more than unmet deductible

Same facts as above except the ESRD-EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 -$80 = $1.

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $75 - $3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. You may not charge the beneficiary since the deductible and coinsurance were met by the ESRD-EGHP payment.

EXAMPLE 3: ESRD-EGHP payment equals unmet deductible

Same facts as above except the ESRD-EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 - $75 = $6.
- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible or coinsurance: $81 - $75 - $3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $3. You may bill the beneficiary $3 for coinsurance. The $75 deductible is satisfied by the ESRD-EGHP payment.

EXAMPLE 4: Deductible met prior to ESRD-EGHP payment.

Same facts as above except the deductible had been met.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 - $72 = $9.

or

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $18* = $63.

*Calculate the coinsurance as follows:

$90 charges X 20 percent = $18 coinsurance.

Medicare pays $9. You may not charge the beneficiary since the coinsurance is paid by ESRD-EGHP payment.

EXAMPLE 5: Per Visit Method

A beneficiary received 4 visits for which you billed $90. No part of the beneficiary's Part B deductible had been met. The ESRD-EGHP paid $72 for Medicare covered services as determined above. The current Medicare interim reimbursement amount at $20 per visit rate is $80. As secondary payer, Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $80 - $72 = $8.

or

o The Medicare reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $80 - $75 - 3* = $2.

*Calculate the coinsurance as follows:

$90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $2. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the ESRD-EGHP payment and $3 by the beneficiary.

Special entries on the bill

Show the identifying information in items 57-75 on the first payer line, value code 13 with the amount paid in value codes (Items 46-49) and occurrence code 33 and the first month of the 12-month period in Items 28-32. In addition, enter the address of the ESRD-EGHP in Item 34 or Remarks (Item 94).

D. ESRD-EGHP Denies Claim for Primary Benefits.--Primary Medicare benefits may be paid (if the beneficiary is not appealing the ESRD-EGHP denial) when an ESRD-EGHP denies a claim for primary benefits because:

o The beneficiary is not in a 12-month coordination period as defined in §§249.4 and 249.5;

o The beneficiary is not entitled to benefits under the plan;

o Benefits under the ESRD-EGHP are exhausted for the services involved; or

o The services are not covered by the ESRD-EGHP.

Where the ESRD-EGHP denies payment for any of the reasons listed above, enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, provide a reason for the denial in Remarks (Item 94). Your intermediary will process the claim.

If an ESRD-EGHP denies a claim for primary benefits because the plan offers only secondary coverage of services covered by Medicare, Medicare benefits may not be paid (primary or conditional). Enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, enter the annotation "Plan offers only secondary coverage of services covered by Medicare" in Remarks (Items 94).

E. Conditional Payments.--If the beneficiary has appealed, or is protesting the ESRD-EGHP denial of the claim for any reason other than that the ESRD-EGHP offers only secondary coverage of services covered by Medicare or it denied the claim because the time limit for filing the claim with the ESRD-EGHP has expired (whether appealed or not) conditional primary Medicare benefits may be paid.

Request conditional payment by entering value code 13 with zero value in Items 46-49 to indicate the type of other insurer and that conditional payment is requested and occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). Enter the identity of the ESRD-EGHP on line A of Item 57, any identifying information about the insured on line A of Items 65-75, and the address of the ESRD-EGHP in Item 34 or Remarks (Item 94). In addition, enter the annotation "Beneficiary has appealed or is protesting ESRD-EGHP denial" or "Time limit for filing the claim with the ESRD-EGHP has expired" as appropriate in Remarks (Item 94).

334. MEDICARE BENEFITS ARE SECONDARY TO GROUP HEALTH PLANS FOR EMPLOYED BENEFICIARIES SPOUSES AND THE DISABLED

A. General.—Medicare benefits are secondary to benefits payable under EGHPs for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. For items and services furnished from January 1, 1985-April 30, 1986, Medicare was secondary payer for employed individuals age 65-69. For items and services furnished from January 1, 1983-December 31, 1984, Medicare was secondary payer for employed individuals age 65-69 and their spouses age 65-69.

Effective for items and services provided on or after January 1, 1987 and before January 1, 1992, Medicare benefits are secondary to benefits payable under large group health plans (LGHPs), i.e., plans that have at least one employer of 100 or more employees for disabled beneficiaries under age 65. When this provision applies, enter value code 43 and the amount paid by the EGHP for Medicare covered services in Items 46-49. Bill as described below. This provision does not apply to beneficiaries entitled to benefits solely on the basis of ESRD.

NOTE: Whenever the term EGHP appears in the remainder of this section and in §§333 and 335, it applies to both the working aged and the disabled.

Payment made by the EGHP can be used to satisfy the unmet deductible and the individual's coinsurance.

Where Medicare is determined to be the primary payer, show Medicare on line A of Item 57. Where Medicare is secondary, show Medicare on line B of Item 57. Where Medicare is not the primary payer because of EGHP coverage, prepare the bill in accordance with the following instructions. It may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §336 for instructions to determine this amount.

B. Outpatient Bills - Full Payment by EGHP.--If an EGHP payment for Medicare covered services (as determined by subsection C below) equals or exceeds your charges for those services or the current Medicare reimbursement amount (without regard to deductible or coinsurance) or you accept, or are obligated to accept the EGHP payment as payment in full, and you know the individual has met his deductible, no bill is submitted.

However, submit a bill to inform the intermediary of charges where the deductible may not be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. Complete the bill in the usual manner. In addition:

o Determine the covered charges as usual, including those covered by the EGHP payment. Your intermediary will treat the charges shown in total charges as noncovered for reimbursement purposes but will credit the deductible based upon the bill;

o Enter the amount paid by the EGHP for Medicare covered services in Items 46-49 (value codes); and

- Enter condition code 77 in Items 35-39 when you accept or are obligated to accept the ESRD-EGHP payment as payment in full.

C. Outpatient Bills - Partial Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined below) is less than your charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and you do not accept, and are not obligated to accept, the EGHP payment as payment in full, prepare the bill in accordance with §318 with the following modifications:

- Determining covered charges.

- Show in the covered charges column, Medicare covered charges including those covered by the EGHP's payment.

- Determining amount of primary payment that applies to Medicare covered services.

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate that amount in value codes (Items 46-49). Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services. Indicate this amount in value codes (Items 46-49). You must be able to validate your ratio of covered and noncovered charges, if requested.

EXAMPLE: Total charges were $110. Medicare covered charges were $90. The EGHP payment was $88. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$90}{\$110} \times \$88 = \$72$$

Show $72 in value codes (Items 46-49).

Determining the amount of Medicare payment.

The Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §336, minus the amount paid by the EGHP for Medicare covered services; or

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §336, minus any applicable deductible or coinsurance amount.

That portion of the total charges equal to the EGHP payment is credited toward any unmet deductible.

NOTE: Examples 1 thru 4 are based upon a percentage of billed charges.

EXAMPLE 1: EGHP payment less than unmet deductible.

Outpatient services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met. The EGHP paid $72 for Medicare covered services as determined above. The Medicare interim reimbursement (without regard to deductible and coinsurance) for these services at 90 percent of charges would be $81. As secondary payer, Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $72 = $9; or

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $75 -$3 = $3.

Calculate the coinsurance as follows:

o $90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the EGHP payment and $3 by the beneficiary.

EXAMPLE 2: EGHP payment more than unmet deductible.

Same facts as above except the EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $80 = $1; or

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $75 -$3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. You may not charge the beneficiary since the deductible and coinsurance were met by the EGHP payment.

EXAMPLE 3: EGHP payment equals unmet deductible

Same facts as above except the EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $75 = $6.

or

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible or coinsurance: $81 - $75 -$3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $3. Bill the beneficiary $3 for coinsurance. The $75 deductible is satisfied by the EGHP payment.

EXAMPLE 4: Deductible met prior to EGHP payment.

Same facts as above except the deductible had been met.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $72 = $9.

or

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $18* = $63.

*Calculate the coinsurance as follows:

$90 charges X 20 percent = $18 coinsurance.

Medicare pays $9. Do not charge the beneficiary since the coinsurance is satisfied by EGHP payment.

EXAMPLE 5: Per Visit Method

A beneficiary received 4 visits for which you billed $90. No part of the beneficiary's Part B deductible had been met. The EGHP paid $72 for Medicare covered services. The current Medicare interim reimbursement amount at $20 per visit rate is $80. As secondary payer, Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the EGHP payment: $80 - $72 = $8.

or

- The Medicare reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $80 - $75 - 3* = $2.

*Calculate the coinsurance as follows:

$90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $2. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the ESRD-EGHP payment and $3 by the beneficiary.

Special entries on the bill

Show the identifying information in Items 57-75 on the first payer line, value code 12 or 43 with the amount paid in value codes (Items 46-49), and the address of the EGHP in Item 34 or remarks (Item 94).

D. EGHP Denies Claim for Primary Benefits.--Primary Medicare benefits may be paid (if the beneficiary is not appealing the EGHP denial) when an EGHP denies a claim for primary benefits because:

- The employer does not employ 20 or more employees;
- The beneficiary is not entitled to benefits under the plan;
- Benefits under the EGHP are exhausted for the services involved; or
- The services are not covered by the EGHP.

Where the EGHP denies payment for any of these reasons, enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, provide a reason for the denial in remarks (Item 94). Your intermediary will process the claim for payment.

If an EGHP denies a claim for primary benefits because the plan offers only secondary coverage of services covered by Medicare and it does not allege and you do not know that the employer has fewer than 20 employees, Medicare benefits may not be paid (primary or conditional). Enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, enter the annotation "Plan offers secondary coverage of services covered by Medicare." Your intermediary will develop to determine if payment can be made. If it is determined that the EGHP employs 20 or more employees your intermediary will deny the claim. Otherwise payment will be made. If the EGHP alleges, or you have documentation that the employer has less than 20 employees, primary Medicare benefits may be paid. Enter the annotation "plan offers secondary coverage of services covered by Medicare/EGHP has fewer than 20 employees" in remarks "Item 94" to avoid development of the claim by your intermediary.

E. Conditional Payments.--If the beneficiary has appealed, or is protesting the EGHP denial of the claim for any reason other than that the EGHP offers only secondary coverage of services covered by Medicare or the EGHP denied the claim because the time limit for filing the claim with the EGHP has expired (whether appealed or not) conditional primary Medicare benefits may be paid.

Request conditional payment by entering value code 12 with zero value in Items 46-49 to indicate the type of other insurer and that conditional payment is requested and occurrence code 24 (insurance denied) and the date of denial in items 28-32 (occurrence codes). Enter the identity of the EGHP on line A of Item 57, any identifying information about the insured on line A of Items 65-75, and the address of the EGHP in Item 34 or remarks (Item 94). In addition, enter the annotation "Beneficiary has appealed or is protesting EGHP denial" or "Time limit for filing the claim has expired" as appropriate in remarks (Item 94).

335. SERVICES ARE REIMBURSABLE UNDER WC

A. General.—Payment may not be made under Medicare for any items or services to the extent that payment has been made, or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or a State.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward the Part B deductible amount.

Where Medicare is determined to be the primary payer, show Medicare on line A of Item 57. Where Medicare is secondary, show Medicare on line B of Item 57. In addition, when you bill Medicare because the WC plan denied payment, enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). Enter the reason for the denial in remarks (Item 94). Where Medicare is not the primary payer because of these provisions, prepare the bill in accordance with the following instructions. It may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). Follow §336 to determine this amount.

B. Outpatient Bills - Full Payment by WC.—If the payment from the WC plan for Medicare covered services (as determined by subsection C below) equals or exceeds your charges for those services, or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or you accept or are required under the WC law to accept, the payment as payment in full, do not submit a bill.

C. Outpatient Bills - Partial Payment by WC.—If the payment from the WC plan for Medicare covered services (as determined below) is less than your charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and you do not accept, and are not required under the WC law to accept the payment as payment in full, prepare the bill in accordance with §318 with the following modifications:

Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the WC plan's payment.

Determining amount of primary payer payment that applies to the Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate that amount in value codes (Items 46-49). Where you can not determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services. Indicate this amount in value codes (Items 46-49). You must be able to validate your ratio of covered and noncovered charges if requested.

EXAMPLE:

Total charges were $200. Medicare covered charges were $180. The WC plan's payment was $55. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$180}{\$200} \times \$55 = \$50$$

Show $50 in value codes (items 46-49).

Determining the amount of Medicare payment

Subtract the payment by the WC plan for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §336. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1: Percentage of Billed Charges

Outpatient care was furnished to a Medicare beneficiary whose WC plan was the primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met. The WC plan paid $50 for Medicare covered services. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges is $162. Calculate the deductible and coinsurance as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services; in this case: $162 - $50 (primary payer's payment) = $112 which exceeds $75. The Part B deductible amount you can charge the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 X 20 percent = $11 coinsurance.

As secondary payer, Medicare pays: the Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the deductible and coinsurance: $162 - $50 - $75 - $11 = $26. Medicare pays $26.

EXAMPLE 2: Percentage of Billed Charges

Same facts as above except the covered charges were $100, the primary payer's payment is $60 and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges is $90. Calculate the deductible and coinsurance as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services, in this case: $90 - $60 = $30. Since $30 is less than $75, the Part B deductible amount charged to the beneficiary is $30.

Since the $75 Part B deductible is not met, there is no coinsurance amount and there is no Medicare payment. The patient's liability is $30 of the $75 deductible.

EXAMPLE 3: Per Visit Method

A beneficiary received 8 visits for which you billed $180.00. No part of the beneficiary's Part B deductible had been met. The WC plan paid $50 for Medicare covered services as determined above. The current Medicare interim reimbursement amount at $20 per visit rate is $160.00. The deductible and coinsurance are as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer's payment for Medicare covered services; in this case: $160 - $50 = $110 which exceeds $75. The Part B deductible amount charged the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 x 20 percent = ($11 coinsurance).

As secondary payer, Medicare pays: the Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the deductible and coinsurance: $160 - $50 - $75 - $11 = $24. Medicare pays $24.

4. Special entries on the bill

Show the identifying information in items 57-75 on the first payer line, occurrence code 04 and the associated date in items 28-32, condition code 02 in items 35-39, value code 15 with the amount paid in value codes (items 46-49), and the address of the WC plan in item 34 or remarks (item 94).

D. Conditional Payments.—Conditional Medicare benefits may be paid while a WC claim is contested. Where a claim is contested, bill Medicare as usual. Request conditional payment by showing occurrence code 04 and the associated date in Items 28-32 occurrence codes and condition code 02 in Items 35-39. Show value code 15 with zero value in Items (46-49) to indicate the type of other insurer and that conditional payment is requested. Identify the other payer on line A of Item 57, and enter on line A of Items 65-75 other identifying information about the insured. Enter the address of the WC plan in Item 34 or remarks (Item 94). Explain why the conditional payment is justified in remarks (Item 94).

336. HOW TO DETERMINE CURRENT MEDICARE INTERIM REIMBURSEMENT AMOUNT

Where application of the procedure requires determining the current Medicare interim reimbursement amount, use the following guidelines before adjustment for other insurance payment:

- Percentage of billed charges - Multiply the current percentage of charges used for the interim rate by the total covered charges. Do not make any reductions for deductible or coinsurance.
- Per Visit - Multiply the per visit interim rate times the number of covered visits. Do not make any reductions for deductible or coinsurance.

Your intermediary can advise you of the applicable percentage or per visit rate and of any changes.

Your interim reimbursement on a bill-by-bill basis will be eliminated or reduced based upon §§332, 333, 334, and 335.

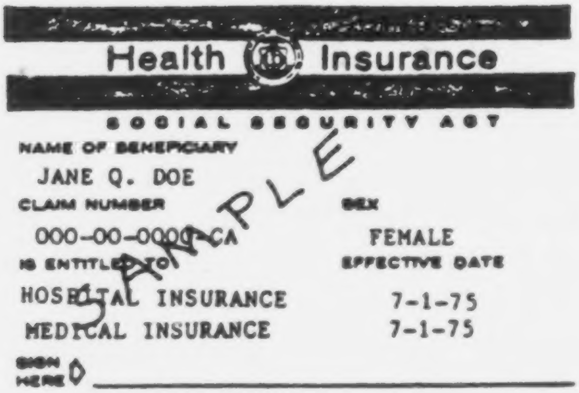
399. EXHIBITS

Exhibit 1 Health Insurance Cards and Claim Numbers

Exhibit 2 Social Security Award Certificate, SSA-L30-C1

Exhibit 3 Temporary Notice of Medicare Eligibility

Exhibit 1



Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

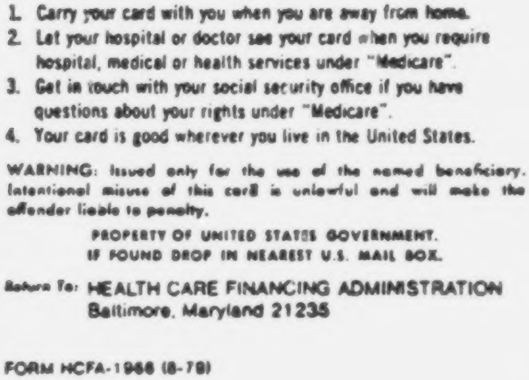
JANE Q. DOE

CLAIM NUMBER	SEX
000-00-0000-CA	FEMALE

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	7-1-75
MEDICAL INSURANCE	7-1-75

SIGN HERE ◊ ______________________________

SAMPLE



1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your social security office if you have questions about your rights under "Medicare".
4. Your card is good wherever you live in the United States.

WARNING: Issued only for the use of the named beneficiary. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

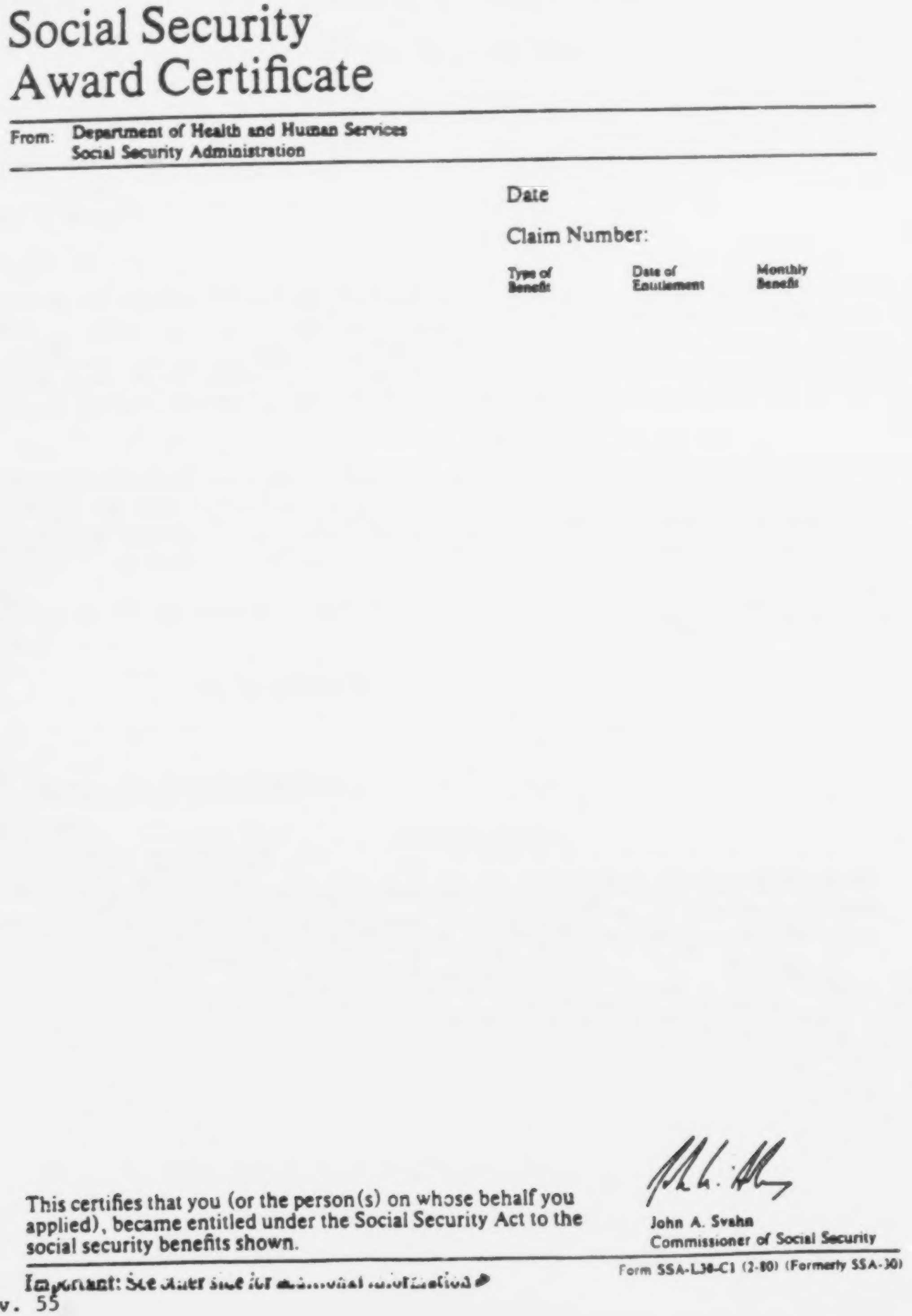
Return To: HEALTH CARE FINANCING ADMINISTRATION
Baltimore, Maryland 21235

FORM HCFA-1966 (8-78)

Exhbit 2

Form SSA-L30-C1 Social Security Award Certificate

Sample Form



Social Security Award Certificate

From: Department of Health and Human Services
Social Security Administration

Date

Claim Number:

Type of Benefit	Date of Entitlement	Monthly Benefit

This certifies that you (or the person(s) on whose behalf you applied), became entitled under the Social Security Act to the social security benefits shown.

John A. Svahn
Commissioner of Social Security

Form SSA-L30-C1 (2-80) (Formerly SSA-30)

Important: See other side for additional information ➧

EXHIBIT 3

TEMPORARY NOTICE OF MEDICARE ELIGIBILITY

District Office Address:

Date:

Patient's Health Insurance
Claim Number

Dear

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning ____(mo.)____ ____(yr.)____ and for supplementary medical insurance benefits beginning ____(mo.)____ ____(yr.)____. This notice will serve as evidence of your (his) eligibility benefits for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services (or reimbursement for medical serivces) before you receive a health insurance card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance care or other notice concerning your eligibility.

Sincerely yours,

Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Health Care Financing Administration should show the patient's health insurance claim number.

ADDENDUM A - PROVIDER ELECTRONIC BILLING FILE AND RECORD FORMATS

	Section	Page
Recommended Physical File Specifications - Magnetic Tape	1	A-2
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File Flowchart	3	A-4
Record Specifications	4	A-5
Key to Records	5	A-6
Record Layouts	6	A-7

1. Recommended Physical File Specifications - Magnetic Tape.—Tape Characteristics -9 Track, 8 1/2" to 10 1/2" reels with silver mylar reflector (standard reels) with write ring removed.

Parity - Odd

Recording Density - 1600 bytes per inch.

Recording Code - Extended Binary Coded Decimal.

File Label - None. The tape must have an end of file mark. The first data record on the file identifies the submitter and the receiver and serves the function of a file label.

Physical Record Length - 192 characters.

Block Size: 1920 characters; i.e., a blocking factor of 10.

Unfilled Final Block - Fill with spaces.

The external label on the reel must appear as follows:

From ____a____ To ____b____
Reel Number ___c___ Claim Types ___d___
Billing Date ___e___
f. ☐ Medicare ☐ Medicaid ☐ Other
Recording Density 1600 BPI

(a) Identification of submitter
(b) Identification of intended recipient
(c) Unique number by which tape is identified in submitter's tape library
(d) Types of claims on the tape; e.g., inpatient hospital, inpatient SNF, outpatient hospital
(e) Date tape created (MMDDYY)
(f) Check one: Medicare, Medicaid, or Other

2. File Specifications - Media Other Than Magnetic Tape.—

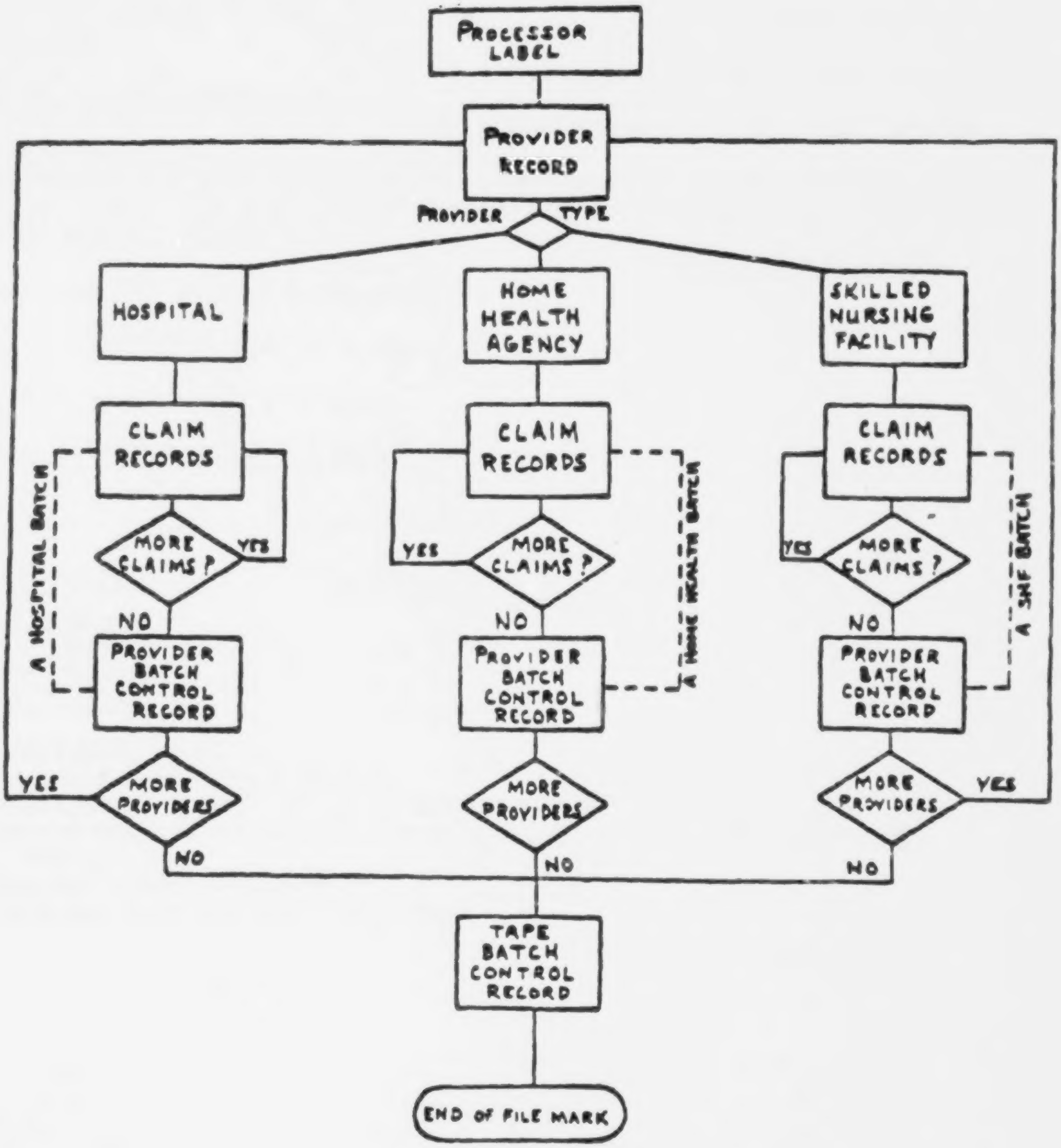
File Label - None

Physical Record Length - 192 characters

External Label - Same as magnetic tape, a thru f

Other specifications will be agreed upon between you and your intermediary with the concurrence of the appropriate Regional Administrator.

3. File Logic - Flowchart.—


PROCESSOR LABEL
PROVIDER RECORD
PROVIDER TYPE
HOSPITAL
HOME HEALTH AGENCY
SKILLED NURSING FACILITY
CLAIM RECORDS
CLAIM RECORDS
CLAIM RECORDS
A HOSPITAL BATCH
A HOME HEALTH BATCH
A SNF BATCH
MORE CLAIMS?
MORE CLAIMS?
MORE CLAIMS?
YES
YES
YES
NO
NO
NO
PROVIDER BATCH CONTROL RECORD
PROVIDER BATCH CONTROL RECORD
PROVIDER BATCH CONTROL RECORD
MORE PROVIDERS
MORE PROVIDERS
MORE PROVIDERS
YES
YES
NO
NO
NO
TAPE BATCH CONTROL RECORD
END OF FILE MARK

4. Record Specifications.—The logical claim record is made up of a series of 192 character physical records. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20-29
Subset 2 - Third Party Data - Record Codes 30-39
Subset 3 - Claim Data - Record Codes 40-49
Subset 4 - Inpatient Accommodations Data - Record Codes 50-59
Subset 5 - Ancillary Services Data - Record Codes 60-69
Subset 6 - Medical Data - Record Codes 70-79
Subset 7 - Physician Data - Record Codes 80-89

The record layouts that follow provide the following data:

1. Record Name: The name of this data record.
2. Record Type: Code indicating the type of record.
3. Record Size: Physical length of record. Constant 192.
4. Field Number
5. Field Name
6. Picture: This is the COBOL picture. Pic X is initialized to blanks, and Pic 9 to zeroes. All money fields and date fields are Pic 9. All code fields that have a legitimate value of zero are Pic X. This makes it possible to detect whether the field has been omitted.
7. Field Specification: This simply indicates how the data field is justified. L = Left justification, and R = Right justification.
8. Position
   From = Leftmost position in the record (high order).
   Thru = Rightmost position in the record (low order).

5. **Key to Records.**

Record Name	Record Type Code
Processor Data	01
Reserved for National Assignment	02-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Non-insured Employment	21
Reserved for National Assignment	22-24
Local Use	25-29
Third Party Insurer Data	30-31
Reserved for National Assignment	32-34
Local Use	35-39
Claim Data	40
Reserved for National Assignment	41-44
Local Use	45-49
Accommodations Data	50
Reserved for National Assignment	51-54
Local Use	55-59
Ancillary Data	60
Procedure Data	61
Reserved for National Assignment	62-64
Local Use	65-69
Medical Data	70
Reserved for National Assignment	71-74
Local Use	75-79
Physician Data	80
Reserved for National Assignment	81-84
Local Use	85-89
Screen	90
Reserved for National Assignment	91-94
Batch Control	95
Local Use	96-98
Tape Control	99

6. Record Layouts

RECORD TYPE 01 - PROCESSOR DATA

- Must be first record on tape
- Must be followed by RT 10.

NOTE: 1) Tapes are formatted so that this is a data record, not a conventional label. From a system standpoint this is a 'labelless' tape.

2) The processor data record is the first record on each reel.

3) This record indicates, in fields 5 thru 7, the class of, and identification of, the organization designated to receive this tape or transmission. If the code in field 5 is a "Z," the file contains records for multiple primary payers. In this case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this tape or transmission. Otherwise, the code in field five designates the types of primary payer, field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for Medicaid, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this tape or transmission. For Blue Cross plans this field is used as designated by the Plan receiving the file.

4) It is recommended that billers and intermediaries establish a protocol limiting a file to a single reel of tape, single disk, cassette, etc. In the event a file exceeds that limit, the reel, disk, etc. must end in a batch control (record type 95).

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Processor Data	01	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '01'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Multiple Provider Billing Tape Indicator	9		12	12
4	Filler	X(18)	L	13	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	9(5)	L	32	36
7	Receiver Sub-Identification	X(4)	L	37	40
8	Processing Date ("Date Bill Submitted" on HCFA-1450)	9(6)	L	41	46
9	Submitter Name	X(21)	L	47	67
	Submitter Address (Fields 10-13)				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	XX	L	101	102
13	ZIP	X(9)	L	103	111
14	Submitter Telephone Number	X(10)	L	112	121
15	Reel Sequence Number	9		122	122
16	Reel Serial Number	X(6)	L	123	128
17	Filler (Reserved for National use)	X(32)		129	160
18	Filler (reserved for local use)	X(29)		161	189
* 19	Version Code	XXX	L	190	192

VERSION 002

RECORD TYPE 10 - PROVIDER

- Must follow either RT 01 or 95.
- Must be followed by RT 20.

NOTE: THIS RECORD MUST BE PRESENT FOR EACH PROVIDER, BATCH COMBINATION.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Provider	10	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '10'	XX	L	1	2
2	Type of Batch	XXX	L	3	5
3	Batch Number	99	R	6	7
4	Federal Tax Number	9(9)	L	8	16
5	Filler	X(6)	L	17	22
6	Medicare Provider Number	X(8)	L	23	30
7	Reserved for Medicare	X(2)	L	31	32
8	Medicaid provider number	X(12)	L	33	44
9	Reserved for Medicaid	X(4)	L	45	48
10	Blue Cross/Blue Shield Provider Number	X(13)	L	49	61
11	Filler	X(9)	L	62	70
12	Provider Telephone Number	X(10)	L	71	80
13	Provider Name	X(18)	L	81	98
	Provider Address (Fields 14-17)				
14	Address	X(18)	L	99	116
15	City	X(15)	L	117	131
16	State	XX	L	132	133
17	ZIP	X(9)	L	134	142
18	Procedure Coding Method Used	9		143	143
19	Filler (reserved for national use)	X(25)		144	168
20	Filler (reserved for local use)	X(24)		169	192

RECORD TYPES 20-2N - Patient

- Must follow either RT 10 or RT 90.
- May be followed by RT 21-2N or 30.
- All records following RT 90 must have the same patient control number.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Patient	20	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '20'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
	Patient Name (Fields 4-6)				
4	Last Name	X(20)	L	22	41
5	First Name	X(10)	L	42	51
6	Middle Initial	X		52	52
7	Patient Sex	X		53	53
8	Patient Birthdate (MMDDYYYY)	9(8)	L	54	61
9	Patient Marital Status	X		62	62
10	Type of Admission	X		63	63
11	Source of Admission	X		64	64
12	Accident Hour	XX	R	65	66
	Patient Address (Fields 13-17)				
13	Address - Line 1	X(18)	L	67	84
14	Address - Line 2	X(18)	L	85	102
15	City	X(15)	L	103	117
16	State	XX	L	118	119
17	ZIP	X(9)	L	120	128
18	Admission Date	9(6)	L	129	134
19	Admission Hour	XX	R	135	136
	Statement Covers Period				
20	From (MMDDYY)	9(6)	L	137	142
21	Thru (MMDDYY)	9(6)	L	143	148
22	Patient Status	99	R	149	150
23	Discharge Hour	XX	R	151	152
24	Patient Has Paid	9(5)V99	R	153	159
25	Medical Record Number	X(18)	L	160	177
26	Filler (Local Use)	X(18)		178	192

RECORD TYPE 21 - Non-insured Employment Information

- Must follow RT 20.
- May be followed by RT 21-2N or 30.
- This record contains employment information pertaining to individuals not claiming insurance but who may have some insurance coverage through their employer from which the patient may be eligible for benefits.
- There are four different individuals to whom this may apply: the patient, the patient's spouse, the patient's father, and the patient's mother. If more than two of these individuals are involved in this claim, use a second record type 21 to submit the relevant employment data for the third, and if applicable, the fourth party involved. Show the sequence number (field 2) of the second Type 21 record as "2".

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Non-insured employment	21	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '21'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	EMPLOYMENT INFORMATION PACKET ONE				
4	Employer Name	X(18)	L	22	39
	Employer Location (Fields 5 - 8)				
5	Employer Address	X(18)	L	40	57
6	Employer City	X(15)	L	58	72
7	Employer State	XX	L	73	74
8	Employer ZIP	X(9)	L	75	83
9	Employee ID Number	X(12)	R	84	95
10	Employment Information Data (P,S,M, or F only)	X		96	96
11	Employment Status Code	9		97	97
	EMPLOYMENT INFORMATION PACKET TWO				
12	Employer Name	X(18)	L	98	115
	Employer Location (Fields 5 - 8)				
13	Employer Address	X(18)	L	116	133
14	Employer City	X(15)	L	134	148
15	Employer State	XX	L	149	150
16	Employer ZIP	X(9)	L	151	159
17	Employee ID Number	X(12)	R	160	171
18	Employment Information Data (P,S,M, or F only)	X		172	172
19	Employment Status Code	9		173	173
20	Filler	X(19)		174	192

RECORD TYPES 30-3N - Third Party Payer

One third party payer record packet (record types 30-3N) appears in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31, etc. depending upon the specific third party payer data required by the particular payer.

Example: Medicare is primary, and the secondary payer requires the insured's address:

	Record Type Code	Sequence Number
Medicare	30	01
Secondary Payer	30	02
	31	02

Note that the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, thus, serving as a matching criterion for the specific third party payer record packet.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	30	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '30'	XX	L	1	2
2	Sequence Number	99	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Source of Payment Code	X		22	22
5	Payer Identification	9(5)	L	23	27
6	Payer Sub-Identification	X(4)	L	28	31
7	Certificate/Social Security Number/ Health Insurance Claim/ Identification Number	X(17)	L	32	48
8	Payer Name	X(16)	L	49	64
9	Primary Payer Code	X		65	65
10	Insurance Group Number	X(20)	L	66	85
11	Insured Group Name	X(17)	L	86	102
	Insured's Name (Fields 11-13)				
12	Last Name	X(20)	L	103	122
13	First Name	X(10)	L	123	132
14	Middle Initial	X		133	133
15	Insured's Sex	X		134	134
16	Release of information Certification Indicator	X		135	135
17	Assignment of Benefits Certification Indicator	X		136	136
18	Patient's Relationship to Insured	99	L	137	138
19	Employment Status Code	9		139	139
20	Covered Days	999	R	140	142
21	Non-Covered Days	9999	R	143	146
22	Coinsurance Days	999	R	147	149
23	Lifetime Reserve Days	99	R	150	151
24	Deductible	9(6)V99	R	152	159
25	Co-Insurance	9(6)V99	R	160	167
26	Estimated Amount Due	9(6)V99	R	168	175
27	Estimated Responsibility	9(6)V99	R	176	183
28	Prior Payments	9(6)V99	R	184	191
29	Filler	X		192	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	31	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '31'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Insured's Address (Fields 4-8)				
4	Address - Line 1	X(18)	L	22	39
5	Address - Line 2	X(18)	L	40	57
6	City	X(15)	L	58	72
7	State	XX	L	73	74
8	ZIP	X(9)	L	75	83
9	Employer Name	X(18)	L	84	101
	Employer Location (Fields 10 - 13)				
10	Employer Address	X(18)	L	102	119
11	Employer City	X(15)	L	120	134
12	Employer State	XX	L	135	136
13	Employer Zip	X(9)	L	137	145
14	Employee ID Number	X(12)	R	146	157
15	Special Program Indicator	99	R	158	159
16	Filler (reserved for national use)	X(10)		160	169
17	Filler (reserved for local use)	X(23)		170	192

RECORD TYPE 40 - 4N - CLAIM

Generally, a claim contains a single type 40 record. However, if the single record is not sufficient to contain all iterations of a particular coding structure, e.g. more than 6 value codes are required, submit additional iterations of record type 40 to convey the additional codes.

For Record Type 40, sequence numbers 02 or higher, all fields except the field or fields required to convey the additional code or codes that could not be contained on the sequence 01 record are initialized to zeroes or blanks as appropriate, with the exception of the Patient Control Number and the Record Type fields.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Claim = '40'	40	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '40'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
4	Type of Bill	999	R	22	24
5	PRO Approval Indicator	9		25	25
	PRO Approved Stay Dates				
6	FROM (MMDDYY)	9(6)	L	26	31
7	THRU (MMDDYY)	9(6)	L	32	37
8	Number of Grace Days	X		38	38
9	Treatment Authorization Code	X(10)	L	39	48
10	Blood - Furnished Pints	999	R	49	51
11	Blood - Replaced Pints	999	R	52	54
12	Blood - Unreplaced Pints	999	R	55	57
13	Blood - Deductible Pints	99	R	58	59
14	Occurrence Code - 1	99	R	60	61
15	Occurrence Date - 1 (MMDDYY)	9(6)	L	62	67
16	Occurrence Code - 2	99	R	68	69
17	Occurrence Date - 2 (MMDDYY)	9(6)	L	70	75
18	Occurrence Code - 3	99	R	76	77
19	Occurrence Date - 3 (MMDDYY)	9(6)	L	78	83
20	Occurrence Code - 4	99	R	84	85
21	Occurrence Date - 4 (MMDDYY)	9(6)	L	86	91
22	Occurrence Code - 5	99	R	92	93
23	Occurrence Date - 5 (MMDDYY)	9(6)	L	94	99
24	Occurrence Span Code - 1	99	L	100	101
	Occurrence Span Date - 1 (Fields 25-26)				
25	Occurrence Span FROM DATE - 1 (MMDYY)	9(6)	L	102	107
26	Occurrence Span THRU DATE - 1 (MMDDYY)	9(6)	L	108	113

NOTE: IF THE CODE IN THE OCCURRENCE CODE FIELD IS OVER 69 THE TWO DATE FIELDS FOLLOWING THAT CODE ARE ASSOCIATED WITH IT, AND THE FIELD FOLLOWING THE FIRST DATE IS ZERO. IF THE CODE ENCOUNTERED IN THE OCCURRENCE SPAN CODE FIELD IS LESS THAN 70, ONLY THE OCCURRENCE SPAN FROM DATE IS COMPLETED. THE CODE AND DATE ARE INTERPRETED AS AN OCCURRENCE CODE.

Claim= 40

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
27	Condition Code - 1	99	R	114	115
28	Condition Code - 2	99	R	116	117
29	Condition Code - 3	99	R	118	119
30	Condition Code - 4	99	R	120	121
31	Condition Code - 5	99	R	122	123
32	Value Code - 1	99	R	124	125
33	Value Amount - 1	9(6)V99	R	126	133
34	Value Code - 2	99	R	134	135
35	Value Amount - 2	9(6)V99	R	136	143
36	Value Code - 3	99	R	144	145
37	Value Amount - 3	9(6)V99	R	146	153
38	Value Code - 4	99	R	154	155
39	Value Amount - 4	9(6)V99	R	156	163
40	Value Code - 5	99	R	164	165
41	Value Amount - 5	9(6)V99	R	166	173
42	Value Code - 6	99	R	174	175
43	Value Amount - 6	9(6)V99	R	176	183
44	Filler	X(9)		184	192

RECORD TYPE 50 - ACCOMMODATION

May be preceded by RT 40 - 4n or 50 - 5n.

May be followed by RT 50 - 5n, 60 or 70.

Enter accommodations in the sequence in which they occur (date sequence).

The sequence number for record type 50 can go from 01 to 99, each such physical record containing five accommodations, thus making provision for reporting up to 495 accommodations on a single claim.

ACCOMMODATION REVENUE CODES: 100 THRU 22X

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
IP Accommodations	50	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record type '50'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Accommodations (occurs 5 times)				
	Accommodations - 1	9(33)	L	22	54
4	Accommodations Revenue Code	999	L	22	24
5	Filler	9		25	25
6	Accommodations Rate	9(4)V99	R	26	31
7	Accommodations Days	9(4)	R	32	35
8	Accommodations Total Charges	S9(5)V99	R	36	42
9	Accommodations Non-Covered Charges	S9(5)V99	R	43	49
10	Filler	9(5)	L	50	54
11	Accommodations - 2	9(33)	L	55	87
12	Accommodations - 3	9(33)	L	88	120
13	Accommodations - 4	9(33)	L	121	153
14	Accommodations - 5	9(33)	L	154	186
15	Filler	X(6)	L	187	192

RECORD TYPE 60 - INPATIENT ANCILLARY SERVICES

May be preceded by RT 40, 50 - 5n or 60 - 6n (excluding 61).

May be followed by RT 60 - 6n (excluding 61), 70 or 80.

The sequence number for record type 60 can go from 01 to 99, each such physical record containing five inpatient ancillary service codes, thus making provision for reporting up to 495 inpatient ancillary services on a single claim.

PAYER AND RELATED INFORMATION (codes 001 - 099).

THESE CODES MAY BE REPORTED IN RECORD TYPE 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RECORD TYPES 90 THRU 9N.

INPATIENT ANCILLARY SERVICES REVENUE CODES: CODES 220 - 99X.

INPATIENT ANCILLARY CODES SHOULD BE IN CODE NUMBER SEQUENCE

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Inpatient Ancillary Services	60	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '60'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Inpatient Ancillaries (occurs 5 times)				
	Inpatient Ancillaries - 1	9(34)	L	22	55
4	Inpatient Ancillary Revenue Code	9(3)	L	22	24
5	Filler	X(12)	L	25	36
6	Inpatient Ancillary Units of Service	999	R	37	39
7	Inpatient Ancillary Total Charges	S9(6)V99	R	40	47
8	Inpatient Ancillary Non-Covered Charges	S9(6)V99	R	48	55
9	Inpatient Ancillaries - 2	9(34)		56	89
10	Inpatient Ancillaries - 3	9(34)		90	123
11	Inpatient Ancillaries - 4	9(34)		124	157
12	Inpatient Ancillaries - 5	9(34)		158	191
13	Filler	X(1)		192	192

RECORD TYPE 61 - OUTPATIENT SERVICES

Must be preceded by RT 40 - 4n.

May be followed by RT 61 - 6n (excluding 60), or 70.

The sequence number for record type 61 can go from 01 to 99, each such physical record containing three outpatient service codes, thus making provision for reporting up to 297 outpatient service codes on a single claim.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Outpatient Services	61	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Revenue Centers (occurs 3 times)				
	Revenue Center - 1	X(57)		22	78
4	Revenue Center Code	999	L	22	24
5	HCPCS Procedure Code	X(5)	L	25	29
6	Modifier 1 (HCPCS & CPT-4)	X(2)	L	30	31
7	Modifier 2 (HCPCS & CPT-4)	X(2)	L	32	33
8	Units	9(4)	R	34	37
9	Date of Service (MMDDYY) (if applicable)	9(6)	L	38	43
10	Charges	9(6)V99	R	44	51
11	Non Covered Charges	9(6)V99	R	52	59
12	Filler	X(19)		60	78
13	Revenue Center - 2	X(57)		79	135
14	Revenue Center - 3	X(57)		136	192

RECORD TYPE 70 - 7N - MEDICAL

May be preceded by RT 50, 60, or 61.

May be followed by RT 7N, 80 or 90.

NOTE: ICD-9-CM CODING IS REQUIRED FOR ALL BILL TYPES. THE ICD-9-CM DIAGNOSIS CODES HAVE BEEN ASSIGNED A COBOL PICTURE OF X. THE ACTUAL CODE IS FORMATTED IN ONE OF FOUR GENERAL WAYS:

1 999.99 MAY INCLUDE ZERO TO TWO DECIMAL PLACES.
2 V99.99 MAY INCLUDE ZERO TO TWO DECIMAL PLACES.
3 E999.9 MAY INCLUDE ZERO TO ONE DECIMAL PLACE.
4 M9999 INCLUDES NO DECIMAL PLACES.

TO DETERMINE THE LOCATION OF THE DECIMAL POSITION AND THE POTENTIAL NUMBER OF DECIMAL POSITIONS IT IS ONLY NECESSARY TO EXAMINE THE HIGH ORDER (LEFTMOST) POSITION IN THE FIELD.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Medical	70	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '70'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Principal Diagnosis Code	X(5)	L	22	26
	Other Diagnosis Codes (fld. 5-8)				
5	Other Diagnosis Code	X(5)	L	27	31
6	Other Diagnosis Code	X(5)	L	32	36
7	Other Diagnosis Code	X(5)	L	37	41
8	Other Diagnosis Code	X(5)	L	42	46
9	Principal Procedure Code	X(5)	L	47	51
10	Filler	X(4)	L	52	55
11	Principal Procedure Date	9(6)	L	56	61
	Other Procedure Codes and Dates (fld. 12 through 17).				
12	Other Procedure Code	X(5)	L	62	66
13	Filler	X(4)	L	67	70
14	Other Procedure Date	9(6)	L	71	76
15	Other Procedure Code	X(5)	L	77	81
16	Filler	X(4)	L	82	85
17	Other Procedure Date	9(6)	L	86	91
18	Admitting Diagnosis Code	9(5)	L	92	96
19	Filler (Local Use)	X(96)		97	192

RECORD TYPE 80 - 8N - PHYSICIAN DATA

- May follow RT 50, 60, or 70 - 7N.
- May be followed by RT 8N, or 90.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Physician Data	80	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '80'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Attending Physician Number	X(16)	L	22	37
5	Operating Physician Number	X(16)	L	38	53
6	Other Physician Number	X(16)	L	54	69
7	Other Physician Number	X(16)	L	70	85
8	Attending Physician Name	X(26)	L	86	111
9	Operating Physician Name	X(26)	L	112	137
10	Other Physician Name	X(26)	L	138	163
11	Other Physician Name	X(26)	L	164	189
12	Filler	X(3)	L	190	192

RECORD TYPE 90 - CLAIM SCREEN

- May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.
- Must be followed by RT 20 or 95.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Screen = '90'	90	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '90'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Physical Record Count (Excluding Screen)	999	R	22	24
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	25	26
6	Record Type 3n Count	99	R	27	28
7	Record Type 4n Count	99	R	29	30
8	Record Type 5n Count	99	R	31	32
9	Record Type 6n Count	99	R	33	34
10	Record Type 7n Count	99	R	35	36
11	Record Type 8n Count	99	R	37	38
12	Total Days/Visits	9(4)	R	39	42
13	Total Accommodation Charges Revenue Centers	S9(7)V99	R	43	51
14	Non-Covered Accommodation Charges - Revenue Centers	S9(7)V99	R	52	60
15	Total Ancillary Charges Revenue Centers	S9(7)V99	R	61	69
16	Non-Covered Ancillary Charges - Revenue Centers	S9(7)V99	R	70	78
17	Remarks	X(114)		79	192

RECORD TYPE 95 - PROVIDER BATCH CONTROL

- Must be preceded by RT 90.
- Must be followed by RT 10 or 99.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Batch Control	95	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '95'	XX	L	1	2
2	Federal Tax Number	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Type of Batch	XXX	L	21	23
6	Number of Claims	9(6)	R	24	29
7	Total Days/Visits	9(6)	R	30	35
8	Accommodations Total Charges for the Batch	S9(8)V99	R	36	45
9	Accommodations Non-Covered Charges for the Batch	S9(8)V99	R	46	55
10	Ancillary Total Charges for the Batch	S9(8)V99	R	56	65
11	Ancillary Non-Covered Charges for the Batch	S9(8)V99	R	66	75
12	Filler (Reserved for National Use)	X(54)	L	76	129
13	Filler (Reserved for Local Use)	X(63)		130	192

RECORD TYPE 99 - TAPE CONTROL

- Must be preceded by RT 95.
- Must be last valid record on tape.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Tape Control	99	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '99'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Number of Batches Billed this Tape	9999	R	21	24
6	Accommodations Total Charges for the Tape	S9(9)V99	R	25	35
7	Accommodations Non-Covered Charges for the Tape	S9(9)V99	R	36	46
8	Ancillary Total Charges for the Tape	S9(9)V99	R	47	57
9	Ancillary Non-Covered Charges for the Tape	S9(9)V99	R	58	68
10	Filler (Reserved for National Use)	X(61)		69	129
11	Filler (Reserved for Local Use)	X(63)		130	192

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

Data Element	Definition	Record	Field
Accident Hour	The hour when the accident occurred that necessitated medical treatment	20	12
* Accommodations Revenue Code	UB-82 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 -14.	4
* Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-82 revenue codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 -14.	7
* Accommodations Non-covered Charges	Accommodations charges pertaining to the related UB-82 accommodations revenue code that are covered by the primary payer as determined by the provider.	50 Four additional iterations in related locations for record 50, fields 11 -14.	9
Accommodations Non-covered Charges for the Batch	Sum of charges recorded in related field in record type 90, field 14	95	9
* Accommodations Rate	Per diem rate for related UB-82 accommodations revenue code.	50 Four additional iterations in related locations for record 50, fields 11 -14.	6
* Accommodations Total Charges	Total charges for the related revenue code.	50	8
Accommodations Total Charges for the Batch	Total accommodation charges for this batch	95	8

* Complete for Medicare

Data Element	Definition	Record	Field
* Admission Date	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care. For an admission notice for hospice care enter the effective date of election of hospice benefits.	20	18
Admission Hour	The hour during which the patient was admitted for inpatient or outpatient care.	20	19
Ancillary Date of Service	The date the associated ancillary service as identified by the UB-82 revenue center code was delivered.	60 Four additional iterations in related locations for record 60, fields 12 -154.	6
Ancillary Non-Covered Charges	Charges pertaining to the related UB-82 ancillary revenue center code that the primary payer will not cover.	60 Four additional iterations in related locations for record 60, fields 12 -15.	9
Ancillary Non-Covered Charges for the Batch	Sum of charges recorded in related field, record type 90, field 16.	95	11
*Ancillary Revenue Code	UB-82 revenue center code for the ancillary services provided. Includes codes 22X through 99X.	60 Four additional iterations in related locations for record 60, fields 12 -15.	4
* Ancillary Total Charges	Total charges pertaining to the related UB-82 ancillary revenue center code. (And date, if applicable.)	60	8
Ancillary Total Charges for the Batch	Total ancillary charges for this batch	95	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Ancillary Units of Service	A quantitative measure of services rendered by UB-82 revenue center category to, or for, the patient to include such items as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 Four additional iterations in related locations for record 60, fields 12 -15.	7
Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits assigned N=Benefits not assigned	30	16
Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment	80	8
* Attending Physician Number	Number assigned to identify physician named in Record 80, field 8	80	4
* Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
* Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.	40	13
* Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient.	40	10
* Blood-Replaced Pints	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.	40	11
* Blood-Unreplaced Pints	The number of pints of whole blood or units of packed red cells furnished to the patient that have not been replaced by or on behalf of the patient.	40	12
Blue Cross/Blue Shield Provider Number	The number assigned to the provider by Blue Cross.	10	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Certificate/ Social Security Number/Health Insurance Claim/ Identification Number	Insured's unique identification number assigned by the payer organization. Medicare: Enter the patient's HICN as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the SSO.	30	7
* Co-Insurance	That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.	30	24
* Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.	30	21
* Condition Codes	A code(s) used to identify conditions relating to this bill that may affect payer processing (See Addendum C.)	40	27-31
* Covered Days	The number of days covered by the primary payer, as qualified by the payer organization.	30	19
* Deductible	That amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer.	30	23
Discharge Hour	Hour that the patient was discharged from inpatient care. (See Addendum C.)	20	23
* Employee ID Number	The identification number assigned by the employer to the insured identified in record 30, fields 11 - 13 as qualified by the payer organization, or as applicable, to the individual indicated by the employment info. code in record 21, field 10, or field 18.	21 31	9&17 14
* Employer Location	The specific location for the employer of the individual identified in record 30.	21 21 31	5-8 13-16 10-13

* Complete for Medicare

Data Element	Definition	Record	Field
*Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in record 30.	21 21 31	4 12 9
* Employment Information Data	A code that indicates whether the employment information given in the related area applies to the patient, the patient's spouse, mother, or father. (See Addendum C.)	21 21	10 18
Employment Status Code	A code used to define the employment status of the individual identified by the "Employment Information Data" code, or by name in record 30. (See Addendum C.)	21 21 30	11 19 18
Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer. (Estimated responsibility less prior payments.)	30	25
Estimated	The amount estimated by the hospital to be paid by the indicated payer.	30	26
Federal Tax Number	The number assigned to the provider by the federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	9
* Insured Address	Insured's current mailing address.	31	4 - 8
	Address Line 1	31	4
	Address Line 2	31	5
	City	31	6
	State	31	7
	ZIP	31	8
Insured Group Name	Name of the group or plan through which the insurance is provided to the insured.	30	10
Insured's Name	Name of the individual in whose name the insurance is carried.	30	11-13
	Last Name	30	11
	First Name	30	12
	Middle Initial	30	13

* Complete for Medicare

Data Element	Definition	Record	Field
* Insured's Sex	A code indicating the sex of the insured. M=Male F=Female U=Unknown	30	14
* Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	22
* Medicaid Provider Number	The number assigned to the provider by Medicaid.	10	8
* Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records	20	25
* Medicare Provider Number	The number assigned to the provider by Medicare.	10	6
* Multiple Provider Billing Tape Indicator	A code indicating whether bills for more than one provider are contained on this tape submission, according to the following coding scheme. 1=Single Provider 2=Multiple Providers	01	3
Non-Covered Charges - Accommodations	Total of accommodation charges not covered by primary payer for this bill as reflected in record type 50, field 9 and subsequent accommodation packets in record type 50.	90	14
* Non-Covered Charges - Ancillaries	Total of "Ancillary Charges-Noncovered" for this bill as reflected in record type 60, field 9.	90	16
* Non-Covered Days	Days of care not covered by the primary payer.	30	20
* Number of Claims	A count of the number of record type 20 entries for this provider batch. (Record type 10 to record type 95.)	95	6
* Number of Batches Billed this Tape.	A count of the number of batches billed on this tape or transmission.	99	5

* Complete for Medicare

Data Element	Definition	Record	Field
* Number of Grace Days	Following the date of the PRO/UR denial determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post discharge care.	40	8
* Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. (See Addendum C.)	40	14, 16 18, 20 22
	Occurrence Code 1	40	14
	Occurrence Code 2	40	16
	Occurrence Code 3	40	18
	Occurrence Code 4	40	20
	Occurrence Code 5	40	22
* Occurrence Date	Date associated with the Occurrence Code in the preceding field.	40	15, 17 19, 21 23
	Occurrence Date 1	40	15
	Occurrence Date 2	40	17
	Occurrence Date 3	40	19
	Occurrence Date 4	40	21
	Occurrence Date 5	40	23
* Occurrence Span Code - 1	A code that identifies an event that relates to the payment of the claim. (See Addendum C.)	40	24
* Occurrence Span Date - 1	The dates related to the Occurrence Span Code shown in the preceding field.	40	25&26
Operating Physician Name	Name used by the provider to identify the operating physician in its records.	80	9
* Operating Physician Number	Number used by the provider to identify the operating physician in its records.	80	5
* Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-existed at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.	70	5-8
Other Physician ID NAME/NUMBER	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	80	6,7, 10&11

* Complete for Medicare

Data Element	Definition	Record	Field
* Other Procedure Codes	The codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill.	70	12, 15
* Other Procedure Dates	Date that the procedure indicated by the related code (preceding field) was performed.	70	14, 17
* Patient Address	The address of the patient as qualified by the payer organization.	20	13-17
	Line 1		13
	Line 2		14
	City		15
	State (P.O. Code)		16
	ZIP		17
* Patient Birthdate	The date of birth of the patient. Includes 4 pos. Year. (MMDDYYYY).	20	9
* Patient Control Number	Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.	20-90	3
* Patient Has Paid	Amount patient has paid to the provider towards this bill.	20	24
Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. (See Addendum C.)	20	12
* Patient Name	Last name, first name, and middle initial of the patient.	20	4 - 6
	Last name	20	4
	First name	20	5
	Middle Initial	20	6
* Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. (See Addendum C.).	30	17
* Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M=Male F=Female U=Unknown	20	7

* Complete for Medicare

Data Element	Definition	Record	Field
* Patient Status	A code indicating patient's status as of the statement covers thru date. (See Addendum C.)	20	22
* Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.	90	4
* Payer Identification	Number identifying each payer organization from which the provider might expect some payment for the bill. (See Addendum C.)	30	5
* Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30	8
Payer Sub-identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.	30	6
* Primary Payer Code	Identifies reason another payer is primary to Medicare. (See Addendum C.)	30	28
* Principal and Other Diagnoses Descriptions	Narrative description of the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the hospitalization or use of hospital services) and other diagnoses. Use ICD-9-CM terminology.	70	19
* Principal Diagnosis Code	The ICD-9-CM diagnosis codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).	70	4
* Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.	70	9
* Principal Procedure Date	The date on which the principal procedure described on the bill was performed.	70	11

* Complete for Medicare

Data Element	Definition	Record	Field
* Principal and Other Procedures Descriptions	A narrative description of the principal procedure (i.e., the procedure that was performed for definitive treatment rather than the one performed for diagnostic or exploratory purposes) or the procedure most related to the principal diagnosis) and other procedures. Show the principal procedure first.	70	20
* Prior Payments - Payer and Patients	The amount the hospital has received toward payment of this bill prior to the billing date by the indicated payer.	30	27
Procedure Code	Procedure code reported in type 61 record to identify physician services so that reimbursement can be made as though the service had been provided in the physician's office.	61	4
Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. (See Addendum C.)	10	18
* Processing date ("Date Bill Submitted" on HCFA-1450).	Date the submitter prepares the file.	01	8
* Provider Address	Complete mailing address to which the provider wishes payment sent.	10	14-17
	Street address or box number	10	14
	City	10	15
	State (P.O. abbreviations)	10	16
	ZIP	10	17
* Provider Name	Name of the provider submitting this batch of bills.	10	13
Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	12
* PRO Approval Indicator	An indicator describing the determination arrived at by the PRO.	40	5

* Complete for Medicare

Data Element	Definition	Record	Field
* PRO Approved Stay Dates	The first and last days that were approved where not all of the stay has been approved by the PRO.	40	6 - 7
* Receiver Identification	Number identifying to the provider the organization designated to receive this file. (See Addendum C.)	01 95 99	6 3 3
Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	01 95 99	7 4 4
* Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission. (See Addendum C.)	01	5
* Record Type nn Count	A count of record types 20-2n through 80-8n, fields 5 through 11 of this record. These fields crossfoot to the total in field 4 of this record.	90	5 -11
* Reel Sequence Number	Sequence number from 01 to nn assigned to each reel in this file of records.	01	15
Reel Serial Number	Inventory number of the reel.	01	16
* Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill State reporting requirements.	90	17
* Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. (See Addendum C.)	30	15

* Complete for Medicare

Data Element	Definition	Record	Field
* Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 20-2n, 40-4n, 70-7n and 80-8n never have a sequence number greater than 01. The sequence number for record types 30 and 31 are used as matching criteria to determine which type 30 and type 31 records are associated, like sequence numbers indicating the records are associated.	30-3n 50-5n 60-6n	2 2 2
* Source of Admission	A code indicating the source of this admission. (See Addendum C.)	20	11
* Source of Payment Code	A code indicating source of payment associated with this payer record. (See Addendum C.)	30	4
* Special Program Indicator	A code indicating that the services included on this bill are related to a special program. (See Addendum C.)	31	16
* Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	20-21
* Submitter Address	Mailing address of the submitter of this file.	01	10-13
	Address		10
	City		11
	State		12
	ZIP		13
* Submitter EIN	Federally assigned Employer Identification Number (EIN) of tape submitter. It is also referred to as Tax Identification Number (TIN).	1 99	2 2

* Complete for Medicare

Data Element	Definition	Record	Field
* Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/processor should direct inquiries regarding this transmittal.	01	9
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	14
* Total Days/Visits	Inpatient bills: the sum of all days reported in accommodation packets in record type 50. Outpatient and home health bills: the sum of all visits recorded as "units of service" for this bill record in record type 60, field 7.	90	12
	Sum of days/visits recorded in record type 90, field 12.	95	7
* Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.	40	9
* Total Charges - Accommodations	Total accommodation charges for this bill	90	13
Total Charges - Ancillaries	Total ancillary charges for this bill	90	15
* Type of Admission	A code indicating the priority of this admission. (See Addendum C.)	20	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Type of Batch	A code indicating the types of bills that occur in this batch; i.e. between a provider record (record type 10), and a provider batch control (record type 95). (See Addendum C.)	10 95	2 5
* Type of Bill	A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.) (See Addendum C.)	40	4
* Value Amount	Amount of money related to the associated value code. (See Addendum C for Value Codes).	40	32, 34, 36, 38 40, 42 44&46
* Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization. (See Addendum C.)	40	33, 35 37, 39 41, 43 45&47
* Version Code	A code that indicates the version of the National Specifications submitted on this reel, disk, etc. 001 = UB-82 data set as finally approved 08/17/82.	01	19

* Complete for Medicare

ADDENDUM C - CODING STRUCTURES

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Data Element: Accident Hour

Definition: The hour when the accident occurred that necessitated medical treatment.

00 - 23; Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01

Noon (12:00-12:59) = 12
01:00-01:59 PM = 13

11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Admission Hour

Definition: The hour during which the patient was admitted for inpatient or outpatient care.

00 - 23; Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01

Noon (12:00-12:59) = 12
01:00-01:59 PM = 13

11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Condition Codes

Data Definition: A Code(s) used to identify conditions relating to this bill that may affect payer processing.

Code Structure:

Code	Code Title	Definition
INSURANCE CODES		
01	Military Service Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
03	Patient Covered by Insurance not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	HMO Enrollee	Medicare beneficiary is enrolled in an HMO.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by, or on behalf of, the patient.
06	ESRD Patient in first year of entitlement covered by EGHP	Code indicates Medicare may be a secondary insurer if the patient is also covered by EGHP insurance during his first year of ESRD entitlement.
07	Treatment of non-terminal condition for hospice patient.	The patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore requesting Medicare reimbursement.
08-16		Reserved for National assignment.
SPECIAL CONDITIONS		
17	Patient is Over 100 years old	Indicates that the patient is over 100 years old at date of admission or outpatient services. Not used for electronic billing.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.

19	Child Retains Mother's Name	A patient who is a dependent child entitled to CHAMPUS or CHAMPVA benefits that does not have his father's last name.
20-30		Reserved for national assignment

STUDENT STATUS (Required when patient is a dependent child over 18 years old)

NOTE: Use only one of the following codes - lowest code value number takes precedence.

31	Patient is student (full time - day)	Patient declares that he or she is enrolled as a full time day student.
32	Patient is student (Cooperative/work study program)	Self Explanatory
33	Patient is student (full time - night)	Patient declares that he or she is enrolled as a full time night student.
34	Patient is student (part time)	Patient declares that he or she is enrolled as a part time student.
35		Reserved for National Assignment.

ACCOMMODATIONS

36	General care patient in a special unit	Patient temporarily placed in special care unit bed because no general care beds available.
37	Ward Accommodation-Patient's Request	Patient assigned to ward accommodations at patient's request.
38	Semi-Private Room Not Available	Indicates that either private or ward accommodations assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	Patient needs a private room for medical requirements.
40	Same Day Transfer	Patient transferred to another facility before midnight of the day of admission.
40-45		Reserved for National Assignment

CHAMPUS INFORMATION

46	Non-Availability Statement on File	A nonavailability statement must be be on file for each CHAMPUS claim for non emergency inpatient care when the CHAMPUS beneficiary resides within the catchment area (usually a 40 mile radius) of a Uniform Services Hospital.
47		Reserved for CHAMPUS.
48-59		Reserved for National Assignment.

PROSPECTIVE PAYMENT

60	Day Outlier	A hospital paid under PPS is reporting this stay as a day outlier.
61	Cost Outlier	A hospital paid under a PPS is requesting additional payment for this stay as a cost outlier.
62	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the claim was paid under a DRG.
63-70		Reserved for National Assignment.

RENAL DIALYSIS SETTING

71	Full Care In Unit	Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72	Self Care in Unit	Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self Care Training	Billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Billing is for a patient who received dialysis services at home but where code 75 below does not apply.
75	Home - 100 Percent Reimbursement	Billing is for a patient who received dialysis services at home using a dialysis machine that was purchased by Medicare under the 100 percent program.

76	Back-up Facility	Billing is for a patient who received dialysis services in a back-up facility.
77-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Discharge hour

Definition: Hour that the patient was discharged from inpatient care:

00 - 23; Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01
Noon (12:00-12:59) = 12
01:00-01:59 PM = 13
11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Employment Information Data.

Definition: A code that indicates whether the employment information given in the related areas applies to an insured, the patient or the patient's spouse.

Code Structure: P - Patient's Employment Information.
S - Spouse's Employment Information.
F - Father's Employment Information.
M - Mother's Employment Information.

Data Element: Employment Status Code.

Definition: A code used to define the employment status of the individual identified by the "Employment Information Data" code.

Code	Code Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.
3	Not employed	Individual states that he or she is not employed full time or part time.
4	Self Employed	Self-explanatory.
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8		Reserved for National assignment.
9	Unknown	Individual's employment status is unknown.

Data Element: Occurrence code.

Definition: A code defining a significant event relating to this bill that may affect payer processing.

ACCIDENT RELATED CODES

01	Auto Accident	Code indicating the date of an auto accident.
02	Auto Accident/ No Fault Insurance Involved	Code indicating the date of an accident where the State has applicable no fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, (other than no fault liability). This date could also be the date of an event for which a third party makes a nonjudical admission of liability. Medicare would become secondary payer in this case.
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident	Code indicating the date of an accident not described by the above codes.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-09		Reserved for National Assignment.

MEDICAL CONDITION CODES

10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity-related condition.
11	Onset of Symptoms/Illness	Date the patient first became aware of symptoms/illness.
12-19		Reserved for National Assignment.

INSURANCE RELATED CODES

20	Guarantee of Payment Began	Code indicating the date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21	UR/PRO Notice Received	Code indicating the date of receipt by the hospital of the UR Committee's (PRO or other responsible group's) finding that an admission or further stay was not medically necessary.
22	Active Care Ended	Code indicating the date on which a covered level of care ended in a general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital. Code not required where PRO/UR approval is completed.
23	Benefits Exhausted	Code indicating the last date for which benefits are being claimed by the provider.
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the provider from the insurer.
25	Date Benefits Terminated By Primary Payer	The date on which coverage (including WC benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	Code indicating the date on which a SNF bed became available to a hospital inpatient who required only SNF level care.
27	Date Home Health Plan Established	Code indicating the date a home health plan of treatment was established (THIS CODE IS ONLY USED BY HOME HEALTH PROVIDERS).
28-39		Reserved for National Assignment.

SERVICE RELATED CODES

40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. This code may only be used on an outpatient claim.
41	Date of First Test for Pre-Admission Testing	The date on which the first outpatient diagnostic test was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	To be used when "Through" date in "Statement Covers Period" is not the discharge date and the frequency code in the "Type of Bill" code is that of a final bill. For a final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care.
43 -49		Reserved for National Assignment.
50-69		Reserved for State Assignment.
70-99		See Occurrence Span Codes. If this code is encountered in an Occurrence Code field, the date following is the "From Date" of the date span, the next Occurrence Code field must be blank and the next date field is the "Through Date" of the date span.

Data Element: Occurrence Span Code-1.

Data Definition: A code that identifies an event that relates to the payment of the claim.

Code Structure

70	Qualifying Stay Dates (Medicare)	The from/through date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates	The from/through dates given by the patient of any hospital, SNF, or nursing home stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the from/through service dates shown in the "Statement Covers Period."
73	Benefit Eligibility Period	The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Noncovered Level of Care	The from/through dates of a period at a noncovered level of care in an otherwise covered stay.
75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Used to show PRO approval of patient's remaining in hospital because SNF bed not available. Code is not applicable to swing bed cases. For hospitals under prospective payment, this code is used in day outlier cases only.
76-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Patient Marital Status.

Definition: The marital status of the patient at date of admission, outpatient service, or start of care:

S - Single
M - Married
X - Legally Separated
D - Divorced
W - Widowed
U - Unknown

Data Element: Patient's Relationship to Insured.

Definition: A code indicating the relationship of the patient to the identified insured:

01	Patient Is Insured	Self - explanatory
02	Spouse	Self - explanatory
03	Natural Child/ Insured has financial responsibility	Self - explanatory
04	Natural Child/ Insured does not have financial responsibility	Self - explanatory
05	Step Child	Self - explanatory
06	Foster Child	Self - explanatory
07	Ward of the Court	Patient is ward of insured as a result of a court order.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
10	Handicapped dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage.
11	Organ donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
12	Cadaver donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.
13	Grandchild	Self - explanatory
14	Niece/Nephew	Self - explanatory
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.
16	Sponsored dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
17	Minor Dependent of a Minor Dependent	Patient is a minor, and the dependent of a minor that is in turn, a dependent but not the child of the insured.
18	Parent	Self explanatory
19	Grandparent	Self explanatory
20 -99		Reserved for National Assignment

Data Element: Patient status.

Definition: A code indicating patient status as of statement covers thru date:

Codes:

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to a SNF
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
08 -09	Reserved for National Assignment
10 -19	Discharge to be defined at State level, if necessary
20	Expired - (or did not recover - Christian Science Patient)
21 -29	Expired (to be defined at State level, if necessary)
30	Still patient
31 -39	Still patient (to be defined at State level, if necessary)
40	Expired at home
41	Expired in a hospital, SNF, or ICF
42	Expired - place unknown
43 -99	Reserved for National Assignment

Data Element: Payer Identification.

Definition: Number identifying each payer organization from which the provider might expect some reimbursement for the bill.

Blue Cross - The Blue Cross number (oonnn)
Commerical Insurers - NAIC assigned number (nnnnn)
Medicaid - State Agency assigned number
Medicare - One or two above, depending upon intermediary
CHAMPUS - NAIC number

Data Element: Primary Payer Code.

Definition: Identifies reason another payer is primary to Medicare.

Codes:

Z	Medicare is Primary
A	Working Aged Bene/Spouse with EGHP
B	ESRD Bene in 12 month period with EGHP
C	Any conditional payment situation
D	Automobile No-Fault or any liability insurance
E	WC including BL
F	VA, PHS, Other Federal Agency

Data Element: Procedure Coding Method Used.

Definition: An indicator that identifies the coding method used for procedure coding on the bill.

1 -3 - Reserved for State and Local Assignment
4 - CPT-4
5 - HCPCS (HCFA Common Procedure Coding System)
6 -8 - Reserved for National Assignment
9 - ICD-9-CM

Data Element: PRO Approval Indicator.

Definition: An indicator describing the determination arrived at by the PRO.

Code 1	Approved as Billed	Code indicates claim has been reviewed by a PRO and has been approved as billed. If the claim is from a hospital being reimbursed under the PPS, it also indicates the PRO has approved any length of stay or cost outlier occurring during the stay.
2	Automatic Approval (Focused Review)	Code indicates claim has not been reviewed by a PRO but has automatic approval as billed since it does not fall into a focused review category.
3	Partial Approval	Code indicates the bill has been reviewed by a PRO and has been only partially approved; i.e., it contains some services which have been determined to be noncovered. If the claim is from a hospital being reimbursed by Medicare under the PPS, it also indicates the PRO has considered, but not fully approved, any length of stay or cost outlier occurring during the stay. The from/through dates of the approved portion of the stay, excluding grace days, and any period at a noncovered level of care is shown in items 88 and 89 of the HCFA-1450.
4	Admission Denied	Code indicates patient's need for hospitalization was reviewed upon admission and the PRO found that none of the stay was medically necessary.
5	Post-payment review Applicable	Code indicates that any PRO review will be completed after the claim is paid. The bill may be a day outlier or part of the sample review, may be reviewed for other reasons, or may not be reviewed.
6-9		Reserved for National Assignment.

Data Element: Receiver Identification

Definition: Number identifying to the provider the organization designated to receive this file. Receivers accepting tapes on behalf of more than one third party payer are identified by their tax identification number.

Data Element: Receiver Type

Definition: A code indicating the class of organization designated to receive this tape or transmittion.

A - Self pay
B - WC
C - Medicare
D - Medicaid
E - Other Federal program
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies
Z - Multiple principal
Sources of payment

Data Element: Release of Information Certification Indicator

Definition: A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Codes:

Y-Yes	The provider has signed a written authority to release medical/billing information for purposes of claiming insurance benefits.
R-Restricted or Modified Release	The provider has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.
N-No Release	The provider does not have permission to release any medical/billing information.

Data Element: Revenue Code

Definition: A Code which identifies a specific accommodation, ancillary service or billing calculation.

Code Structure:

Major Category

PAYER AND RELATED INFORMATION (codes 001 - 099).

NOTE: REPORT THESE CODES IN RECORD TYPE 60, BUT DO NOT INCLUDE THE AMOUNTS ASSOCIATED WITH THEM IN CONTROL TOTALS MAINTAINED IN RECORD TYPES 90 THRU 9N.

Rationale: To group items by payer and to assign similar items the same number.

001 Total Charge

01X
to
06X Reserved for National Assignment

07X
to
09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

Flat fee charge incurred on either a daily or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

	Subcategory	Standard Abbreviations
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All-Inclusive Room and Board	ALL INCL R&B

11X Room & Board - Private
Medical or General

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
9 - Other	OTHER/PVT

12X Room & Board - Semi-private Two Bed
(Medical or General)

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Room and Board - Semi-Private

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
9 - Other	OTHER/2BED

13X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED
6 - Detoxification	DETOX/3&4BED
7 - Oncology	ONCOLOGY/3&4BED
9 - Other	OTHER/3&4BED

14X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of thore provided to other patients.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX
3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
9 - Other	OTHER/DLX

15X Room & Board Ward (Medical or General)

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
9 - Other	OTHER/WARD

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

17X **Nursery**

Charges for nursing care to newborn and premature infants in nurseries.

Rationale: Provides a breakdown of various levels of nursery care. Tertiary care is a level of care between premature and regular nursery care.

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn	NURSERY/NEWBORN
2 - Premature	NURSERY/PREMIE
5 - NeoNatal ICU	NURSERY/ICU
9 - Other	NURSERY/OTHER

18X **Leave of Absence**

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

NOTE: Charges are billable for codes 2 - 5

Subcategory	Standard Abbreviation
0 - General Classification	LEAVE OF ABSENCE OR LOA
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Theraputic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

19X Not Assigned

20X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - PRE/Post ICU	PRE/POST ICU
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0 - General Classification	CORONARY CARE or (CCU)
1 - Myocardial Infarction	CCU/MYO INFARC
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - PRE/Post-CCU	PRE/POST CCU
9 - Other Coronary Care	CCU/OTHER

ANCILLARY REVENUE CODES (22X - 99X)

22X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services rendered in greater detail and thus break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - UR Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

23X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

24X All Inclusive Ancillary

A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0 - General Classification	ALL INCL ANCIL
9 - Other Inclusive Ancillary	ALL INCL ANCIL/OTHER

25X Pharmacy

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Non-generic drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Non-prescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X IV Therapy

Administration of intravenous solution by specially trained personnel to individuals requiring such treatment. Use this code only when a discrete service unit exists.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY
1 - Infusion Pump	IV THER/INFSN PUMP
9 - Other IV Therapy	IV THERAPY/OTHER

27X Medical/Surgical Supplies

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic Devices	PROSTHETIC DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTRA OC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Devices	SUPPLY/OTHER

28X Oncology

Charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

29X Durable Medical Equipment (Other Than Renal)

Charge for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
9 - Other Equipment	MED EQUIP/OTHER

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Nonroutine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMOTOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

31X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
1 - Angiocardiography	DX X-RAY/ANGIO
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided of the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of Ohio.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service rendered.

Subcategory	Standard Abbreviation
0 - General Classification	NUCLEAR MEDICINE or (NUC MED)
1 - Diagnostic	NUC MED/DX
2 - Therapeutic	NUC MED/RX
9 - Other	NUC MED/OTHER

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	CT SCAN
1 - Head Scan	CT SCAN/HEAD
2 - Body Scan	CT SCAN/BODY
9 - Other CT Scans	CT SCAN/OTHER

36X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

37X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture is identified because it is not covered by some payers, including Medicare.

Subcategory	Standard Abbreviation
0 - General Classification	ANESTHESIA
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

38X Blood

Rationale: Charges for blood are separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PLATELETS
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives (Cryopricipatates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

40X **Other Imaging Services**

Subcategory	Standard Abbreviation
0 - General Classification	IMAGE SERVICE
1 - Mammography	MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
9 - Other Imaging Services	OTHER IMAG SVS

41X **Respiratory Services**

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

42X **Physical Therapy**

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

45X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers

Subcategory	Standard Abbreviation
0 - General Classification	EMERG ROOM
9 - Other Emergency Room	OTHER EMER ROOM

46X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital

Subcategory	Standard Abbreviation
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

48X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category reflects a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
9 - Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

50X Outpatient Services

Outpatient charges (other than those for scheduled Preadmission Testing) for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of services. These charges are incorporated on the inpatient bill of Medicare patients.

51X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
9 - Other Clinic	OTHER CLINIC

52X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice	FAMILY PRACTICE
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: There is a service unique to osteopathic hospitals which cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviations
0 - General Classification	OSTEOPATH SVS
1 - Osteopathic Therapy	OSTEOPATH RX
9 - Other Osteopathic Services	OTHER OSTEOPATH

54X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 - General Classification	AMBULANCE
1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/0XY
5 - Air Ambulance	AIR AMBULANCE
6 - Neo-natal ambulance	AMBUL/NEO-NATAL
9 - Other Ambulance	OTHER AMBULANCE

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by a HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Charges by a HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

59X Units of Service (Home Health)

Revenue code used by a HHA that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

60X Not Assigned (May be reserved for other Clinics)

61X MRI

Charges for Magnetic Reasonance Imaging of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	MRI
1 - Brain (including Brainstem)	MRI - BRAIN
2 - Spinal Cord (including Spine)	MRI - SPINE
9 - Other MRI	MRI - OTHER

62X Not Assigned

63X Not Assigned

64X Not Assigned

65X Hospice Services

Charges for hospice care services for a terminally ill patient if he elected these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care - 1/2	HOSPICE/CTNS HOME
5 - Inpatient Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (Non-Respite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYS SVC
9 - Other Hospice	HOSPICE/OTHER

66X Not Assigned

67X Not Assigned

68X Not Assigned

69X Not Assigned

70X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	CAST ROOM
9 - Other Cast Room	OTHER CAST ROOM

71X Recovery Room

Rationale: Permits identification of particular services if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry (includes fetal monitoring)	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

74X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

75X **Gastro-Intestinal Services**

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviation
0 - General Classification	GASTR-INTS SVS
9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

76X **Not Assigned**

77X **Not Assigned**

78X **Not Assigned**

79X **Lithotripsy**

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abbreviation
0 - General Classification	LITHOTRIPSY
9 - Other Lithotripsy	LITHOTRIPSY/OTHER

80X **Inpatient Renal Dialysis**

A waste removal process, performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

81X **Organ Acquisition**

The acquisition of a kidney, heart or liver for use in transplantation.

Rationale: Living donor is a living person from whom a kidney, heart, or liver is obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom a kidney or heart is obtained for transplantation.

Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	KIDNEY ACQUISIT
1 - Living Donor - Kidney	KIDNEY/LIVE
2 - Cadaver Donor - Kidney	KIDNEY/CADAVER
3 - Unknown Donor - Kidney	KIDNEY/UNKNOWN
4 - Other Kidney Acquisition	KIDNEY/OTHER
5 - Cadaver Donor - Heart	HEART/CADAVER
6 - Other Heart Acquisition	HEART/OTHER
7 - Donor - Liver	LIVER ACQUISIT
9 - Other Organ Acquisition	ORGAN/OTHER

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required; therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance/100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

83X Peritoneal dialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance/100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 - Other Peritoneal Dialysis	PERTNL/HOME/OTHER

84X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CAPD/OP OR HOME
1-CAPD/Composite or other rate	CAPD/OP/COMPOSITE
2-Home Supplies	CAPD/HOME/SUPPL
3-Home Equipment	CAPD/HOME/EQUIP
4-Maintenance/100%	CAPD/HOME/100%
5-Support Services	CAPD/HOME/SUPSERV
9-Other CAPD Dialysis	CAPD/HOME/OTHER

85X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CCPD/OP OR HOME
1-CCPD/Composite or other rate	CCPD/OP/COMPOSITE
2-Home Supplies	CCPD/HOME/SUPPL
3-Home Equipment	CCPD/HOME/EQUIP
4-Maintenance/100%	CCPD/HOME/100%
5-Support Services	CCPD/HOME/SUPSERV
9-Other CCPD Dialysis	CCPD/HOME/OTHER

86X Reserved for Dialysis (National Assignment)

87X Reserved for Dialysis (State Assignment)

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultrafiltration	DIALY/ULTRAFILT
9 - Misc. Dialysis Other	DIALY/MISC/OTHER

89X Other Donor Bank

Charges for the acquisition, storage and preservation of all human organs (excluding kidneys).

Rationale: Provides a breakdown identifying the specific organ category.

Subcategory	Standard Abbreviation
0 - General Classification	DONOR BANK
1 - Bone	DONOR BANK/BONE
2 - Organ (other than kidney)	DONOR BANK/ORGN
3 - Skin	DONOR BANK/SKIN
9 - Other Donor Bank	OTHER DONOR BANK

90X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
9 - Other	OTHER PSTAY RX

91X Psychiatric/Psychological Services

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Rationale: Provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY SERVICES
1 - Rehabilitation	PSTAY/REHAB
2 - Day Care	PSTAY/DAYCARE
3 - Night Care	PSTAY/NIGHTCARE
4 - Individual Therapy	PSTAY/INDIV RX
5 - Group Therapy	PSTAY/GROUP RX
6 - Family Therapy	PSTAY/FAMILY RX
7 - Bio Feedback	PSTAY/BIOFEED
8 - Testing	PSTAY/TESTING
9 - Other	PSTAY/OTHER

92X Other Diagnostic Services

Charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

93X Not Assigned

94X **Other Therapeutic Services**

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Air Fluidized Support Beds	AIR FLUID BEDS
9 - Other Therapeutic Services	ADDITIONAL RX SVS

95X **Not Assigned**

96X **Professional Fees**

Charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSTAY
2 - Opthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

97X **Professionals Fees (cont.)**

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

98X **Professional Fees (cont.)**

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X **Patient Convenience Items**

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

Data Element: Source of admission

Definition: A code indicating the source of this admission.

Code:

1 - Physician Referral	The patient was admitted to this facility upon the recommendation of a personal physician.
2 - Clinic Referral	The patient was admitted to this facility upon the recommendation of this facility's clinic physician.
3 - HMO Referral	The patient was admitted to this facility upon the recommendation of a HMOs physician.
4 - Transfer from a Hospital	The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.
5 - Transfer from a SNF	The patient was admitted to this facility as a transfer from a SNF where he or she was an inpatient.
6 - Transfer from Another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a SNF.
7 - Emergency Room	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
8 - Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9 - Information Not Available	The means by which the patient was admitted to this hospital is not known.

Code Structure (Newborn):

1 - Normal Delivery	A baby delivered without complications.
2 - Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3 - Sick baby	A baby delivered with medical complications, other than those relating to premature status.
4 - Extra Mural Birth	A newborn born in a non-sterile environment.
5 -8	Reserved for national assignment
9 -	Information Not Available

Data Element: Source of Payment

Definition: A code indicating source of payment associated with this payer record.

A - Self pay
B - WC
C - Medicare
D - Medicaid
E - Other Federal Programs
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies

Data Element: Special Program Indicator

Definition: A code indicating that the services included on this bill are related to a special program.

Code Structure

01	EPSDT/CHAP	Early and Periodic Screening, Diagnosis and Treatment.
02	Physically Handicapped Children's Program	Services provided under this program receive special funding through Title VIII of the Social Security Act or the CHAMPUS Program for the Handicapped.
03	Special Federal Funding	This code has been designed for uniform use by State uniform billing committees.
04	Family Planning	This code has been designed for uniform use by State uniform billing committees.
05	Disability	This code has been designed for uniform use by State uniform billing committees.
06	PPV/Medicare 100% payment	This code identifies that pneumococcal pneumonia vaccine (PPV) services given are reimbursed under a special Medicare program provision.
07	Induced abortion - danger to life	Abortion was performed to avoid danger to woman's life.
08	Induced abortion Victim rape/incest	Self explanatory.
09-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Type of Admission

Definition: A Code indicating the priority of this admission.

1 = Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was through the emergency room.
2 = Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally the patient was admitted to the first available and suitable accommodation.
3 = Elective schedule	The patient's condition permitted adequate time to the availability of a suitable accommodation.
4 = Newborn	Necessitates the use of special Source of Admission codes.
5-8	Reserved for National Assignment
9	Information Not Available

Data Element: Type of batch

Definition: A code indicating the type of bill that occurs in this batch; i.e., between a provider record (record type 10) and a batch control (record type 95). The "Type of Batch" code is the same as the "Type of Bill" code shown on the following page.

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Code Structure

Type of Facility - 1st Digit	
Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Special Facility	8
Reserved for National Use	9

Bill Classification (Except Clinics and Special Facilities) - 2nd Digit	
Inpatient (Including Part A)	1
Inpatient (Part B only)	2
Outpatient	3
Other (for Medicare Part B use only)	4
Intermediate Care - Level I	5
Intermediate Care - Level II	6
Intermediate Care - Level III	7
Swing Beds	8
Reserved for National Assignment	9

Bill Classification (Clinics) 2nd digit		Bill Classification - Special Facilities - 2nd digit
Rural Health	1	Hospice (non-hospital based)
Free Standing Renal Dialysis Center	2	Hospice (hospital based)
Free Standing	3	Ambulatory Surgical Center
CORF	4	Free Standing Birthing Center
Reserved for National Use	5-8	Reserved for National Use
Other	9	Other

Frequency - 3rd Digit	
Non-Payment/Zero claim	0
Admit thru Discharge Claim	1
Interim - First claim	2
Interim - Continuing claim	3
Interim - Last claim	4
Late Charge(s) Only Claim	5
Adjustment of prior claim	6
Replacement of prior claim	7
Void/cancel of prior claim	8
Reserve for National Assignment	9

Data Element: Value Code

Data Definition: A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-Private Rooms	Entering this code requires $0.00 amount.
05	Professional Component included in Charges and also billed separate to Carrier.	For use on Medicare and Medicaid bills if State specifies the need for this information.
06	Medicare Blood Deductible	Total cash blood deductible, if appropriate.
07	Medicare Cash Deductible	Medicare cash deductible to be used only if 06 is used and there is a cash deductible.
08	Medicare Life Time Reserve Amount in the first calendar year.	Medicare life time reserve amount charged in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year.	Medicare co-insurance amount charged in the year of admission.
10	Medicare Life Time Reserve Amount in the second calendar year.	Medicare life time reserve amount charged in the year of discharge where the bill spans two calendar years.
11	Medicare Coinsurance Amount in the second Calendar Year.	Medicare co-insurance amount charged in the year of discharge where the bill spans two calendar years.
12	Working Aged Beneficiary/ Spouse with EGHP	Amount shown is that portion of a payment from a higher priority EGHP made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.

13	**ESRD Beneficiary in the 12 month coordination period EGHP**	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
14	**Automobile, No Fault or any Liability Insurance**	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
15	**WC including BL**	Amount shown is that portion of a payment from higher priority WC insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
16	**VA, PHS, other Federal Agency**	Amount shown is that portion of a payment from as higher priority VA, PHS, or other Federal Agency made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
17	**Payer Code**	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
18-20		Reserved for National Assignment.

MEDICAID SPECIFIC CODES

21	**Catastrophic**	Medicaid-eligibility requirements to be determined at State level.
22	**Surplus**	Medicaid-eligibility requirements to be determined at State level.
23	**Recurring Monthly Income**	Medicaid-eligibility requirements to be determined at State level.
24	**Medicaid Rate Code**	Medicaid-eligibility requirements to be determined at state level.
25-29		Reserved for National Assignment - Medicaid.
30	**Preadmission Testing**	Reflects charges for preadmission outpatient diagnostic services for a patient in preparation for a previously scheduled admission.
31-79		Reserved for National Assignment.
80-99		Reserved for State and local assignment.

ADDENDUM D - DME, PROSTHETICS AND ORTHOTICS HCPCS CODES AND DEFINITIONS

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Inexpensive or Routinely Purchased	D - 2
Items Requiring Frequent Maintenance	D - 8
Prosthetics and Orthotics	D - 9
Capped Rental	D - 48
Oxygen	D - 54
Need Prescription Before Delivery	D - 57

INEXPENSIVE OR ROUTINELY PURCHASED

E0100 (b)	CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP
E0105 (b)	CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS
E0110 (b)	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS
E0111 (b)	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS
E0112 (i)	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS
E0113 (i)	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP
E0114 (i)	CRUTCHES UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS
E0116 (i)	CRUTCH UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP
E0130 (i)	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0135 (i)	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0141 (i)	WALKER WHEELED, WITHOUT SEAT
E0142 (i)	RIGID WALKER, WHEELED, WITH SEAT
E0143 (i)	FOLDING WALKER, WHEELED, WITHOUT SEAT
E0147 (r)	HEAVY DUTY, MULTIPLE BREAKING SYSTEM, VARIABLE WHEEL RESISTANCE WALKER
E0150 (b)	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH
E0151 (b)	HANDGRIP, CANE, CRUTCH, OR WALKER REPLACEMENT, EACH
E0152 (b)	TIP, CANE OR CRUTCH WALKER REPLACEMENT, EACH
E0153 (i)	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH
E0154 (i)	PLATFORM ATTACHMENT, WALKER, EACH

INEXPENSIVE OR ROUTINELY PURCHASED

E0155 (b)	WHEEL ATTACHMENT, RIGID PICK-UP WALKER ATTACHMENTS
E0156 (b)	SEAT ATTACHMENT, WALKER
E0157 (i)	CRUTCH ATTACHMENT, WALKER, EACH
E0158 (b)	LEG EXTENSIONS FOR A WALKER
E0160 (i)	SITZ TYPE BATH, PORTABLE, FITS OVER COMMODE SEAT
E0161 (b)	SITZ TYPE BATH, PORTABLE, FITS OVER COMMODE SEAT, WITH FAUCET ATTACHMENTS
E0163 (i)	COMMODE CHAIR, STATIONARY, WITH FIXED ARMS
E0164 (i)	COMMODE CHAIR, MOBILE, WITH FIXED ARMS
E0167 (b)	PAIL OR PAN FOR USE WITH COMMODE CHAIR
E0184 (r)	FLOTATION MATTRESS, DRY
E0185 (i)	DECUBITUS CARE PAD, FLOTATION OR GEL PAD WITH FOAM LEVELING PAD (MATTRESS SIZE)
E0188 (b)	SYNTHETIC SHEEPSKIN PAD
E0189 (b)	LAMBSWOOL SHEEPSKIN PAD, ANY SIZE
E0195 (b)	REPLACEMENT PAID FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY THE PATIENT
E0200 (i)	HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT
E0205 (b)	HEAT LAMP, WITH STAND, INCLUDES BULB, OR INFRARED ELEMENT
E0210 (b)	ELECTRIC HEAT PAD, STANDARD
E0215 (b)	ELECTRIC HEAT PAD, MOIST
E0237 (r)	WATER CIRCULATING HEAT PAD WITH PUMP
E0238 (b)	NONELECTRIC HEAT PAD, MOIST
E0239 (b)	HYDROCOLLATOR UNIT, PORTABLE

INEXPENSIVE OR ROUTINELY PURCHASED

E0271 (r)	MATTRESS, INNERSPRING
E0275 (b)	BED PAN, STANDRAD, METAL, OR PLASTIC
E0276 (b)	BED PAN, FRACTURE, METAL OR PLASTIC
E0310 (I)	BED SIDE RAILS, FULL LENGTH
E0325 (b)	URINAL, MALE, ANY MATERIAL
E0326 (b)	URINAL, FEMALE, ANY MATERIAL
E0330 (b)	URINAL, MALE, DAY/NIGHT
E0560 (b)	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY, E.G., CASCADE JR.
E0605 (b)	VAPORIZER, ROOM TYPE
E0607 (r)	HOME BLOOD GLUCOSE MONITOR
E0609 (r)	BLOOD GLUCOSE MONITOR WITH SPECIAL FEATURES (EG., VOICE SYNTHESIZERS AUTOMATIC TIMERS, ECT.)
E0610 (i)	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, INCLUDED AUDIBLE AND VISIBLE CHECK SYSTEMS)
E0615 (i)	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, AND OTHER PACEMAKER COMPONENTS, INCLUDES DIGITAL/VISIBLE CHECK SYSTEMS)
E0620 (r)	SEAT LIFT CHAIR, MOTORIZED TO ASSIST PATIENT IN STANDING AND SITTING
E0621 (b)	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON
E0650 (r)	PNEUMATIC COMPRESSOR, NONSEGMENTAL HOME MODEL, (LYMPHEDEMA PUMP)
E0651 (r)	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL, (LYMPHEDEMA PUMP) WITHOUT CALIBRATED GRADIENT PRESSURE
E0655 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
E0660 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG

INEXPENSIVE OR ROUTINELY PURCHASED

E0665 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0666 (r)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0667 (r)	PNEUMATIC APPLIANCE FOR USE WITH SEGMENTAL PNEUMATIC COMPRESSOR, LEG
E0690 (r)	ULTRAVIOLET CABINET, APPROPRIATE FOR HOME USE
E0747 (r)	OSTEOGENESIS STIMULATOR (NON-INVASIVE)
E0776 (I)	IV POLE
E0782 (b)	INFUSION PUMP, IMPLANTABLE
E0840 (i)	TRACTION FRAME, ATTACHED TO HEADBOARD, SIMPLE CERVICAL TRACTION
E0850 (i)	TRACTION STAND, FREE STANDING, SIMPLE CERVICAL TRACTION
E0860 (b)	TRACTION EQUIPMENT, OVERDOOR, CERVICAL
E0870 (i)	TRACTION FRAME, ATTACHED TO FOOTBOARD, SIMPLE EXTREMITY TRACTION, (E.G., BUCK'S)
E0880 (i)	TRACTION STAND, FREE STANDING, SIMPLE EXTREMITY TRACTION (E.G., BUCK'S)
E0890 (i)	TRACTION FRAME, ATTACHED TO FOOTBOARD, SIMPLE PELVIC TRACTION
E0900 (i)	TRACTION STAND, FREE STANDING, SIMPLE PELVIC TRACTION (E.G., BUCK'S)
E0942 (b)	CERVICAL HEAD HARNESS/HALTER
E0944 (b)	PELVIC BELT/HARNESS/BOOT
E0945 (b)	EXTREMITY BELT/HARNESS
E0947 (b)	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION
E0948 (b)	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX CERVICAL TRACTION

INEXPENSIVE OR ROUTINELY PURCHASED

E0953 (b)	PNEUMATIC TIRE, EACH
E0954 (b)	SEMI-PNEUMATIC CASTER, EACH
E0959 (i)	AMPUTEE ADAPTER (DEVICE USED TO COMPENSATE FOR TRANSFER OF WEIGHT DUE TO LOST LIMBS TO MAINTAIN PROPER BALANCE)
E0961 (b)	BRAKE EXTENSION, FOR WHEELCHAIR
E0962 (b)	1" CUSHION, FOR WHEELCHAIR
E0963 (b)	2" CUSHION, FOR WHEELCHAIR
E0964 (b)	3" CUSHION, FOR WHEELCHAIR
E0965 (b)	4" CUSHION, FOR WHEELCHAIR
E0966 (b)	HOOK ON HEAD REST EXTENSION
E0967 (b)	WHEELCHAIR HAND RIMS WITH 8 VERTICAL RUBBER TIPPED PROJECTIONS, PAIR
E0969 (i)	NARROWING DEVICE, WHEELCHAIR
E0970 (b)	NO. 2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST
E0971 (b)	ANTI-TIPPING DEVICE WHEELCHAIRS
E0972 (b)	TRANSFER BOARD, WHEELCHAIR
E0973 (b)	ADJUSTABLE HEIGHT DETACHABLE ARMS, DESK OR FULL LENGTH, WHEELCHAIR
E0975 (b)	REINFORCED SEAT UPHOLSTERY, WHEELCHAIR
E0976 (b)	REINFORCED BACK UPHOLSTERY, WHEELCHAIR
E0990 (b)	ELEVATING LEG REST, EACH
E0991 (b)	UPHOLSTERY SEAT
E0992 (b)	SOLID SEAT INSERT
E0993 (b)	BACK UPHOLSTERY
E0994 (b)	ARM REST, EACH

INEXPENSIVE OR ROUTINELY PURCHASED

E0995 (b)	CALF REST, EACH
E0996 (b)	TIRE, SOLID, EACH
E0997 (b)	CASTER WITH A FORK
E0998 (b)	CASTER WITHOUT FORK
E0999 (b)	PNEUMATIC TIRE WITH WHEEL
E1000 (b)	TIRE, PNEUMATIC CASTER
E1001 (b)	WHEEL, SINGLE
E1005 (b)	REPLACEMENT, BATTERIES FOR MEDICALLY NECESSARY ELECTRIC WHEELCHAIR OWNED BY THE PATIENT
E1065 (r)	POWER ATTACHMENT (TO CONVERT ANY WHEELCHAIR TO MOTORIZED WHEELCHAIR, E.G., SOLO)
E1066 (r)	BATTERY CHARGER
E1069 (b)	DEEP CYCLE BATTERY
E1226 (r)	FULL RECLINING BACK FOR CUSTOMIZED WHEELCHAIR
E1227 (r)	SPECIAL HEIGHT ARMS FOR WHEELCHAIR
E1230 (r)	POWER OPERATED VEHICLE (3WHEEL NONHIGHWAY) INDICATE BRAND NAME AND MODEL NUMBER
E1296 (r)	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR
E1297 (r)	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY
E1298 (r)	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION
E1356 (b)	BREATHING CIRCUITS
E1372 (i)	IMMERSION EXTERNAL HEATER FOR NEBULIZER

i = INEXPENSIVE

r = ROUTINE

b = BOTH

ITEMS REQUIRING FREQUENT MAINTENANCE

E0450	VOLUME VENTILATOR
E0451	VOLUME VENTILATOR, PORTABLE
E0500	IPPB MACHINES WITH MANUAL VALVES EXTERNAL POWER SOURCE, INCLUDES CYCLINDER REGULATOR, BUILT-IN NEBULIZATION
E0505	IPPB MACHINES WITH MANUAL VALUES ELECTRICALLY DRIVEN WITH INTERNAL POWER SOURCE, BUILT-IN NEBULIZATION
E0510	IPPB MACHINES WITH AUTOMATIC VALVES, EXTERNAL POWER SOURCE INCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION
E0515	IPPB MACHINES WITH AUTOMATIC VALVES, ELECTRICALLY DRIVEN WITH INTERNAL COMPRESSOR, BUILT-IN NEBULIZATION
E0570	NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID
E0575	NEBULIZER, SELF-CONTAINED, ULTRASONIC
E0585	NEBULIZER, WITH COMPRESSOR AND HEATER
E0600	SUCTION PUMP, HOME MODEL, PORTABLE
E0601	NASAL CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE
E0674	IRON LUNG
E0935	PASSIVE MOTION EXERCISE DEVICE
E1375	NEBULIZER PORTABLE WITH SMALL COMPRESSOR, WITH LIMITED FLOW

PROSTHETICS AND ORTHOTICS

A4214	STERILE SALINE OR WATER, 30 CC VIAL
A425[illegible]	IRRIGATION KITS, NONSTERILE
A4341	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, TEFLON
A4342	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, LATEX
A4343	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, LATEX WITH TEFLON COATING
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE
A4345	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, SILICONE WITH ELASTOMER COATING
A4346	INDWELLING CATHETER, FOLEY TYPE, THREE WAY, LATEX OR TEFLON FOR CONTINUOUS IRRIGATION
A4347	EXTERNAL CATHETER, CONDOM TYPE
A4348	URINARY COLLECTION AND RETENTION SYSTEM, DRAINAGE BAG WITH TUBE
A4349	URINARY COLLECTION AND RETENTION SYSTEM, LEG BAG WITH TUBE
A4350	CATHETER CARE KIT
A4353	CATHETER INSERTION TRAY WITH CATHETER INCLUDING TUBING AND DRAINAGE BAG
A4354	CATHETER INSERTION TRAY WITHOUT CATHETER INCLUDING TUBING AND DRAINAGE BAG
A4355	3-WAY IRRIGATION SET FOR CATHETER EXTERNAL URINARY SUPPLIES
A4356	INCONTINENCE CLAMP
A4357	URINARY DRAINAGE BAG
A4358	URINARY LEG BAG
A4359	URINARY SUSPENSORY
A4360	COLOSTOMY SET

PROSTHETICS AND ORTHOTICS

A4361	OSTOMY FACE PLATE
A4362	OSTOMY SKIN BARRIER
A4363	OSTOMY LIQUID BARRIER
A4364	OSTOMY SKIN BOND OR CEMENT
A4365	OSTOMY BAG, DISPOSABLE/CLOSED
A4366	OSTOMY BAG, REUSEABLE OR DRAINABLE
A4367	OSTOMY BELT
A4368	STOMA WICKS
A4369	TAIL CLOSURES
A4370	OSTOMY SKIN BOND OR CEMENT, REMOVER
A4380	ILEOSTOMY SET
A4390	ILEAL BLADDER SET
A4400	IRRIGATION SET FOR IRRIGATION OF OSTOMY
A4402	OSTOMY LUBRICANT
A4404	OSTOMY RINGS
A4421	NOT OTHERWISE CLASSIFIED OSTOMY SUPPLIES
A4430	URETEROSTOMY SET
A4440	NOT OTHERWISE CLASSIFIED URETEROSTOMY SUPPLIES
E0720	TENS, TWO LEAD, LOCALIZED STIMULATION
E0730	TENS, FOUR LEAD, LARGER, AREA/MULTIPLE NERVE STIMULATION
E0740	REPLACEMENT BATTERIES FOR MEDICALLY NECESSARY TENS OWNED BY THE PATIENT
E1373	TRACHEOTOMY MASK OR COLLAR
L0100	CERVICAL, CRANIOSTENOSIS, HELMET MOLDED TO PATIENT MODEL
L0110	CERVICAL, CRANIOSTENOSIS, HELMET, NONMOLDED

PROSTHETICS AND ORTHOTICS

L0120	CERVICAL, FLEXIBLE, NONADJUSTABLE (FOAM COLLAR)
L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT
L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)
L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT
L0170	CERVICAL, COLLAR, MOLDED TO PATIENT MODEL
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO PIECE
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION
L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE
L0190	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MADNIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILFORD, TAYLOR TYPES)
L0200	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS AND THORACIC EXTENSION
L0210	THORACIC, RIB BELT, CUSTOM FITTED
L0220	THORACIC, RIB BELT, CUSTOM FABRICATED
L0300	THORACIC-LUMBAR-SACRAL-ORTHOSIS (TLSO), FLEXIBLE (DORSO-LUMBAR SURGICAL SUPPORT), CUSTOM FITTED
L0310	TLSO, FLEXIBLE, (DORSO-LUMBAR SURGICAL SUPPORT), CUSTOM FABRICATED
L0320	TLSO, ANTERIOR-POSTERIOR CONTROL (TAYLOR TYPE), WITH APRON FRONT
L0330	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (KNIGHT-TAYLOR TYPE) WITH APRON FRONT
L0340	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL (ARNOLD, MAGNUSON, STEINDLER TYPES), WITH APRON FRONT

PROSTHETICS AND ORTHOTICS

L0350	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, FLEXION COMPRESSION JACKET, CUSTOM FITTED
L0360	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, FLEXION COMPRESSION JACKET MOLDED TO PATIENT MODEL
L0370	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, HYPEREXTENSION (JEWETT, LENNOX, BAKER, CASH TYPES)
L0380	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, WITH ANTERIOR EXTENSIONS
L0390	TLSO, ANTERIOR-POSTERIOR-LETERAL CONTROL (BODY JACKET) MOLDED TO PATIENT MODEL
L0400	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET) MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0410	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), TWO PIECE CONSTRUCTION, MOLDED TO PATIENT MODEL
L0420	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), TWO PIECE CONSTRUCTION, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0430	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), WITH INTERFACE MATERIAL CUSTOM FITTED
L0440	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), WITH OVERLAPPING FRONT SECTION, SPRING STEEL FRONT, CUSTOM FITTED
L0500	LUMBAR-SACRAL-ORTHOSIS (LSO), FLEXIBLE, (LUMBO-SACRAL SURGICAL SUPPORT), CUSTOM FITTED
L0510	LSO, FLEXIBLE (LUMBO-SACRAL SURGICAL SUPPORT), CUSTOM FABRICATED
L0515	LSO, FLEXIBLE, (LUMBO-SACRAL SURGICAL SUPPORT) ELASTIC TYPE, WITH RIGID POSTERIOR PANEL
	ANTERIOR-POSTERIOR-LATERAL CONTROL
L0520	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (KNIGHT, WILCOX TYPES), WITH APRON FRONT

PROSTHETICS AND ORTHOTICS

L0530	LSO, ANTERIOR-POSTERIOR CONTROL (MACAUSLAND TYPE), WITH APRON FRONT
L0540	LSO, LUBMAR FLEXION (WILLIAMS FLEXION TYPE) ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET)
L0550	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), MOLDED TO PATIENT MODEL
L0560	LSO, ANTERIOR-POSTERIOR LATERAL CONTROL (BODY JACKET), MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0565	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), CUSTOM FITTED
L0600	SACROILIAC, FLEXIBLE (SACROILIAC SURGICAL SUPPORT), CUSTOM FITTED
L0610	SACROILIAC, FLEXIBLE (SACROILIAC SURGICAL SUPPORT), CUSTOM FABRICATED
L0620	SACROILIAC, SEMI-RIGID (GOLDTHWAITE, OSGOOD TYPES), WITH APRON FRONT
L0700	CERVICAL-THORACIC-LUMBAR-SACRAL-ORTHOSES (CTLSO), ANTERIOR-POTERIOR-LATERAL CONTROL, MOLDED TO PATIENT MODEL, (MINERVA TYPE)
L0710	CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERVA TYPE)
L0810	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO JACKET VEST
L0820	HALO PROCEDURE, CERVICAL HOLO INCORPORATED INTO PLASTER BODY JACKET
L0830	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO MILWAUKEE TYPE ORTHOSIS
L0900	TORSO SUPPORT, PTOSIS SUPPORT, CUSTOM FITTED
L0910	TORSO SUPPORT, PTOSIS SUPPORT, CUSTOM FABRICATED
L0920	TORSO SUPPORT, PENDULOUS ABDOMEN SUPPORT, CUSTOM FITTED

PROSTHETICS AND ORTHOTICS

L0930	TORSO SUPPORT, PENDULOUS ABDOMEN SUPPORT, CUSTOM FABRICATED
L0940	TORSO SUPPORT, POST SURGICAL SUPPORT, CUSTOM FITTED
L0950	TORSO SUPPORT, POST SURGICAL SUPPORT, CUSTOM FABRICATED
L0960	TORSO SUPPORT, POST SURGICAL SUPPORT, PADS FOR POST SURGICAL SUPPORT
L0970	TLSO, CORSET FRONT
L0972	LSO, CORSET FRONT
L0974	TLSO, FULL CORSET
L0976	LSO, FULL CORSET
L0978	AXILLARY CRUTCH EXTENSION
L0980	PERONEAL STRAPS, PAIR
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4)
L1000	CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS, INCLUDING MODEL
L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) OR SCOLIOSIS ORTHOSIS, AXILLA SLING
L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD
L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING
L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD
L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD
L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD
L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD
L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZE SLING
L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER
L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS

PROSTHETICS AND ORTHOTICS

L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING
L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER
L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL
L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH
L1200	THORACIC-LUMBAR-SACRAL-ORTHOSIS (TLSO), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS ONLY
L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION AWAY DETACHABLE FOOT RESTS
L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION
L1230	ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE
L1240	ADDITION TO TLSO (LOW PROFILE), LUMBAR DEROTATION PAD
L1250	ADDITION TO TLSO (LOW PROFILE), ANTERIOR ASIS PAD
L1260	ADDITION TO TLSO (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD
L1270	ADDITION TO TLSO (LOW PROFILE), ABDOMINAL PAD
L1280	ADDITION TO TLSO (LOW PROFILE), RIB GUSSET (ELASTIC), EACH
L1290	ADDITION TO TLSO (LOW PROFILE), LATERAL TROCHANTERIC PAD
L1300	OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL
L1310	OTHER SCOLIOSIS PROCEDURE, OST-OPERATIVE BODY JACKET
L1499	UNLISTED PROCEDURE FOR SPINAL ORTHOSIS
L1500	THORACIC-HIP-KNEE-ANKLE ORTHOSIS (THKAO), MOBILITY FRAME (NEWINGTON, PARAPODIUM TYPES)
L1510	THKAO, STANDING FRAME
L1520	THKAO, SWIVEL WALKER

PROSTHETICS AND ORTHOTICS

L1600	HIP ORTHOSIS (HO), ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER
L1610	HO, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA COVER ONLY
L1620	HO, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, PAVLIK HARNESS
L1630	HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE)
L1640	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS
L1650	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, CUSTOM FITTED (ILFLED TYPE)
L1660	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC, CUSTOM FITTED
L1670	HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, ATTACHED TO SHOE (CRAIG TYPE)
L1680	HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUSTABLE HIP MOTION CONTROL, THIGH CUFFS (RANCHO HIP ACTION TYPE)
L1685	HO, ABDUCTION CONTROL OF HIP JOINTS, POST-OPERATIVE HIP ABDUCTION TYPE
L1700	LEGG PERTHES ORTHOSIS, TORONTO TYPE
L1710	LEGG PERTHES ORTHOSIS, NEWINGTON TYPE
L1720	LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)
L1730	LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE
L1750	LEGG PERTHES ORTHOSIS, LEGG PERTHES SLING (SAM BROWN TYPE)
L1755	LEGG PERTHES ORTHOSIS, PATTEN BOTTOM TYPE
L1800	KNEE ORTHOSIS (KO), ELASTIC WITH STAYS
L1810	KO, ELASTIC WITH JOINTS

PROSTHETICS AND ORTHOTICS

L1815	KO, ELASTIC WITH CONDYLAR PADS
L1820	KO, ELASTIC WITH CONDYLAR PADS AND JOINTS
L1825	KO, ELASTIC KNEE CAP
L1830	KO, IMMOBILIZER, CANVAS LONGITUDINAL
L1840	KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL
L1845	KO, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT, MEDIAL-LATERAL AND ROTATION CONTROL, CUSTOM FITTED
L1846	KO, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT, MEDIAL-LATERAL AND ROTATION CONTROL, MOLDED TO PATIENT MODEL
L1850	KO, SWEDISH TYPE
L1855	KO, MOLDED PLASTIC, THIGH AND CALF SECTIONS, WITH DOUBLE UPRIGHT KNEE JOINTS, MOLDED TO PATIENT MODEL
L1858	KO, MOLDED PLASTIC, POLYCENTRIC KNEE JOINTS, PNEUMATIC KNEE PADS (CTI)
L1860	KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)
L1870	KO, DOUBLE UPRIGHT, THIGH AND CALF LACERS, MOLDED TO PATIENT MODEL WITH KNEE JOINTS
L1880	KO, DOUBLE UPRIGHT, NONMOLDED THIGH AND CALF CUFFS/LACERS WITH KNEE JOINTS
L1900	ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND
L1902	AFO, ANKLE GUANTLET, CUSTOM FITTED
L1904	AFO, MOLDED ANKLE GAUNTLET, MOLDED TO PATIENT MODEL
L1906	AFO, MULTILIGAMENTUS ANKLE SUPPORT
L1910	AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER
L1920	AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE)

PROSTHETICS AND ORTHOTICS

L1930	AFO, CUSTOM FITTED, PLASTIC
L1940	AFO, MOLDED TO PATIENT MODEL, PLASTIC
L1950	AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC
L1960	AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC
L1970	AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT
L1980	AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR "BK" ORTHOSIS)
L1990	AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR "BK" ORTHOSIS)
NOTE:	L2000, L2020, and L2036 ARE BASE PROCEDURES TO BE USED WITH ANY KNEE JOINT, L2010 and L2030 ARE TO BE USED ONLY WITH NO KNEE JOINT
L2000	KNEE-ANKLE-FOOT-ORTHOSES (KAFO), SINGLE STIRRUP, FREE KNEE, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR "AK" ORTHOSIS)
L2010	KAFO, SINGLE UPRIGHT, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR "AK" ORTHOSIS) WITHOUT KNEE JOINT
L2020	KAFO, DOUBLE UPRIGHT, FREE KNEE, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOBULE BAR "AK" ORTHOSIS)
L2030	KAFO, DOUBLE UPRIGHT, ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR "AK" ORTHOSIS), WITHOUT KNEE JOINT
L2036	KAFO, FULL PLASTIC, MOLDED TO PATIENT MODEL
L2040	HIP-KNEE-ANKLE-FOOT-ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT
L2050	HKAFO TORSION CONTROL, BILATERAL TORISON CABLES, HIP JOINT, PELVIC BAND/BELT
L2060	HKAFO TORSION CONTROL, BILATERAL TORISON CABLES, BALL BEARING HIP JOINT, PELVIC BAND/BELT
L2070	HKAFO TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT

PROSTHETICS AND ORTHOTICS

L2080	HKAFO TORSION CONTROL, UNILATERAL TORISON CABLE, HIP JOINT, PELVIC BAND/BELT
L2090	HKAFO TORSION CONTROL, UNILATERAL TORISON CABLE, BALL BEARING HIP JOINT PELVIC BAND/BELT
L2102	ANKLE-FOOT-ORTHOSIS (AFO), FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, PLASTER TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2104	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SYNTHETIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2106	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2108	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL
L2112	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SOFT CUSTOM FITTED
L2114	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SEMI-RIGID CUSTOM FITTED
L2116	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, RIGID CUSTOM FITTED
L2122	KNEE-ANGLE-FOOT-ORTHOSIS, (KAFO), FRACTURE FEMORAL FRACTURE CAST ORTHOSIS, PLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2124	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SYNTHETIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2126	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2128	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL
L2132	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT CUSTOM FITTED
L2134	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID CUSTOM FITTED
L2136	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID CUSTOM FITTED

PROSTHETICS AND ORTHOTICS

L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS
L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINTS
L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT
L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM
L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT
L2200	ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT
L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT
L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT
L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT
L2240	ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PAITENT MODEL, STIRRUP ATTACHMENT
L2260	ADDITION TO LOWER EXTREMITY, REINFORCED SOLID STIRRUP (SCOTT-CRAIG TYPE)
L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION ("T") STRAP, PADDED/LINED OR MALLELUS PAD
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT

PROSTHETICS AND ORTHOTICS

L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE
L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR-STRAIGHT
L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED LACER
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL
L2335	ADDITION OT LOWER EXTREMITY, ANTERIOR SWING BAND
L2340	ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL
L2350	ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)
L2360	ADDITION TO LOWER EXTREMITY, EXTENDED STEEL SHANK
L2370	ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM
L2375	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, ANKLE JOINT AND HALF SOLID STIRRUP
L2380	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, STRAIGHT KNEE JOINT, EACH JOINT
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, EACH JOINT
L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, EACH JOINT
L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, HEAVY DUTY, EACH JOINT
L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH JOINT
L2415	ADDITION TO KNEE JOINT, CAM LOCK (SWISS, FRENCH, BAIL TYPES) EACH JOINT
L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXITON, EACH JOINT
L2435	ADDITION TO KNEE JOINT, POLYCENTRIC JOINT, EACH JOINT
L2475	ADDITION TO KNEE JOINT, BAIL LOCK, EACH JOINT

PROSTHETICS AND ORTHOTICS

L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING
L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GULTEAL/ISCHIAL WEIGHT BEARING, RING
L2510	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUANDRILATERAL BRIM, MOLDED TO PATIENT MODEL
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUANDRILATERAL BRIM, CUSTOM FITTED
L2530	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, NON-MOLDED
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL
L2550	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, HIGH ROLL CUFF
L2560	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING
L2570	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING, TWO POSITION HIP JOINT
L2580	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING, PELVIC SLING
L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH
L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, LOCK, EACH
L2620	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH
L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH
L2624	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, ABDUCTION CONTROL, EACH
L2626	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, RECIPROCATING HIP JOINTS, AND CABLES
L2630	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL

PROSTHETICS AND ORTHOTICS

L2640	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL
L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH
L2660	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND
L2670	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS
L2680	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR
L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSTION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)
L2770	ADDITION TO LOWER EXTREMITY ORTHOSIS, STAINLESS STEEL-PER BAR OR JOINT
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NONCORROSIVE FINISH, PER BAR
L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH
L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP
L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, KNEE CAP, MEDICAL OR LATERAL PULL
L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD
L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION
L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION
L2999	UNLISTED PROCEDURES FOR LOWER EXTERMITY ORTHOSES

PROSTHETICS AND ORTHOTICS

L3650	SHOULDER ORTHOSIS, (SO), FIGURE OF "8" DESIGN ABDUCTION RESTRAINER
L3660	SO, FIGURE OF "8" DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING
L3670	SO, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE)
L3700	ELBOW ORTHOSES (EO), ELASTIC WITH STAYS
L3710	EO, ELASTIC WITH METAL JOINTS DOUBLE UPRIGHT
L3720	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION
L3730	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/FLEXION ASSIST
L3740	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL
L3800	WRIST-HAND-FINGER-ORTHOSES (WHFO), SHORT OPPENTS, NO ATTACHMENTS
L3805	WHFO, LONG OPPONENS, NONATTACHMENT
L3810	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB ABDUCTION ("C") BAR
L3815	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SECOND M.P. ABDUCTION ASSIST
L3820	WHFO, ADDITION TO SHORT AND LONG OPPONENS, I.P. EXTENSION ASSIST, WITH M.O. EXTENSION STOP
L3825	WHFO, ADDITION OT SHORT AND LONG OPPONENS, M.P. EXTENSION
L3830	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSON ASSIST
L3835	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. SPRING EXTENSION ASSIST
L3840	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SPRING SWIVEL THUMB
L3845	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB I.P. EXTENSION ASSIST, WITH M.P. STOP

PROSTHETICS AND ORTHOTICS

L3850	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ACTION WRIST, WITH DORSIFLEXION ASSIST
L3855	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL
L3860	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL AND I.P.
L3900	WHFO, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION WRIST OR FINGER DRIVEN
L3901	WHFO, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION, CABLE DRIVEN
L3902	WHFO, EXTERNAL POWER, COMPRESSED GAS
L3904	WHFO, EXTERNAL POWER, ELECTRIC
L3906	WHFO, WRIST GAUNTLET, MOLDED TO PATIENT MODEL
L3907	WHFO, WRIST GAUNTLET WITH THUMB SPICA, MOLDED TO PATIENT MODEL
L3908	WHFO, WRIST EXTENSION CONTROL COCK-UP, CANVAS OR LEATHER DESIGN, NON-MOLDED
L3910	WHFO, SWANSON DESIGN
L3912	WHFO, FLEXION GLOVE WITH ELASTIC FINGER CONTROL
L3914	WHFO, WRIST EXTENSION COCK-UP
L3916	WHFO, WRIST EXTENSION COCK-UP, WITH OUTRIGGER
L3918	WHFO, KNUCKLE BENDER
L3920	WHFO, KNUCKLE BENDER, WITH OUTRIGGER
L3922	WHFO, KNUCKLE BENDER, TWO SEGMENT TO FLEX JOINTS
L3924	WHFO, OPPENHEIMER
L3926	WHFO, THOMAS SUSPENSION
L3928	WHFO, FINGER EXTENSION, WITH CLOCK SPRING

PROSTHETICS AND ORTHOTICS

L3930	WHFO, FINGER EXTENSION, WITH WRIST SUPPORT
L3932	WHFO, SAFETY PIN, SPRING WIRE
L3934	WHFO, SAFETY PIN, MODIFIED
L3936	WHFO, PALMER
L3938	WHFO, DORSAL WRIST
L3940	WHFO, DORSAL WRIST, WITH OUTRIGGER ATTACHMENT
L3942	WHFO, REVERSE KNUCKLE BENDER
L3944	WHFO, REVERSE KNUCKLE BENDER, WITH OUTRIGGER
L3946	WHFO, COMPOSITE ELASTIC
L3948	WHFO, FINGER KNUCKLE BENDER
L3950	WHFO, COMBINATION OPPENHEIMER, WITH KNUCKLE BENDER AND TWO ATTACHMENTS
L3952	WHFO, COMBINATION OPPENHEIMER, WITH REVERSE KNUCKLE BENDER AND TWO ATTACHMENTS
L3954	WHFO, SPREADING HAND
L3960	SHOULDER-ELBOW-WRIST-HAND ORTHOSIS, (SEWHO), ABDUCTION
L3962	SEWHO, ABDUCTION POSITIONING, ERBS PALSEY DESIGN
L3963	SEWHO, MOLDER SHOULDER, ARM, FOREARM, AND WRIST, WITH ARTICULATING ELBOW JOINT
L3964	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, ADJUSTABLE
L3965	SEWHO, SEMI-RADIAL ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, ADJUSTABLE RANCHO TYPE
L3966	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, RECLINING
L3968	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)

PROSTHETICS AND ORTHOTICS

L3969	SEWHO, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, VOKE TYPE ARM SUSPENSION SUPPORT
L3970	SEWHO, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROMXIMAL ARM
L3972	SEWHO, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
L3974	SEWHO, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR
L3980	UPPER EXTREMITY FRACTURE ORTHOSIS, HUMERAL
L3982	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR
L3984	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST
L3985	UPPER EXTREMITY FRACTURE ORTHOSIS, FOREARM, HAND WITH WRIST HINGE
L3986	UPPER EXTREMITY FRACTURE ORTHOSIS, COMBINATION OF HUMERAL, RADIUS/ULNAR, WRIST, (EXAMPLE—COLLES FRACTURE)
L3999	UNLISTED PROCEDURES FOR UPPER LIMB ORTHOSIS
L4000	REPLACE GRIDLE FOR MILWAUKEE ORTHOSIS
L4010	REPLACE TRILATERAL SOCKET BRIM
L4020	REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL
L4030	REPLACE QUARDRILATERAL SOCKET BRIM, CUSTOM FITTED
L4040	REPLACE MOLDED THIGH LACER
L4045	REPLACE NONMOLDED THIGH LACER
L4050	REPLACE MOLDED CALF LACER
L4055	REPLACE NONMOLDED CALF LACER
L4060	REPLACE HIGH ROLL CUFF
L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO
L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH

PROSTHETICS AND ORTHOTICS

L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH
L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH
L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH
L4130	REPLACE PRETIBIAL SHELL
L4200	REPAIR OF ORTHOTIC DEVICE, HOURLY RATE
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L5000	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER
L5010	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLLER
L5020	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER
L5050	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT
L5060	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT
L5100	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT
L5110	BELOW KNEE, WOOD SOCKET, JOINTS AND THIGH LACER, SACH FOOT
L5150	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT
L5160	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT
L5200	ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5210	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ("STUBBIES"), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH
L5220	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ("STUBBIES"), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY ALIGNED, EACH
L5230	ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT

PROSTHETICS AND ORTHOTICS

L5250	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5270	HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5280	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5300	BELOW KNEE, MOLDED SOCKET, SACH FOOT, ENDOSKELETAL SYSTEM, INCLUDING SOFT COVER AND FINISHING
L5310	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, SACH FOOT ENDOSKELETAL SYSTEM, INCLUDING SOFT COVER AND FINISHING
L5320	ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE, INCLUDING SOFT COVER AND FINISHING
L5330	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT, INCLUDING SOFT COVER AND FINISHING
L5340	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT, INCLUDING SOFT COVER AND FINISHING
L5400	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT, SUSPENSION, AND ONE CAST CHANGE, BELOW KNEE
L5410	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT AND SUSPENSION, BELOW KNEE, EACH ADDITIONAL CAST CHANGE AND REALIGHMENT
L5420	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGHMENT AND SUSPENSION AND ONE CAST CHANGE "AK" OR KNEE DISARTICULATION
L5430	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING, FITTING, ALIGNMENT AND SUPENSION, "AK" OR KNEE DISARTICULATION, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT

PROSTHETICS AND ORTHOTICS

L5450	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, BELOW KNEE
L5460	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE KNEE
L5500	INITIAL, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, DIRECT FORMED
L5505	INITIAL, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, 'USMC' OR EQUAL PYLON, NO COVER, SACH FOOT PLASTER SOCKET, DIRECT FORMED
L5510	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET, 'USMC' OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL
L5520	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORMED
L5530	PREPARTORY, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO MODEL
L5540	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL
L5560	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL
L5570	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORM
L5580	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLED TO MODEL
L5585	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJUSTABLE OPEN END SOCKET
L5590	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATON ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL

PROSTHETICS AND ORTHOTICS

L5610	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, HYDRACADENCE SYSTEM
L5616	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, UNIVERSAL MULTIPLEX SYSTEM, FRICTION SWING PHASE CONTROL
L5618	ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES
L5620	ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE
L5622	ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION
L5624	ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE
L5626	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION
L5628	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY
L5630	ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET
L5632	ADDITION TO LOWER EXTREMITY, SYMES TYPE, "PTB" BRIM DESIGN SOCKET
L5634	ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET
L5636	ADDITION TO LOWER EXTREMITY, SYMES TYPE, MEDIAL OPENING SOCKET
L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET
L5640	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, LEATHER SOCKET
L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET
L5643	ADDITION TO LOWER EXTREMITY, HIP DISARTICULATION, FLEXIBLE INNER SOCKET, EXTERNAL FRAME
L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME

PROSTHETICS AND ORTHOTICS

L5646	ADDITION TO LOWER EXTREMITY, BELOW KNEE, AIR CUSHION SOCKET
L5647	ADDITION TO LOWER EXTREMITY, BELOW KNEE SUCTION SOCKET
L5648	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, AIR CUSHION SOCKET
L5649	ADDITION TO LOWER EXTREMITY, CAT-CAM SOCKET
L5650	ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET
L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME
L5652	ADDITION TO LOWER EXTREMITY, SUCTION SUSPENSION, ABOVE KNEE OR KNEE DISARTICULATION SOCKET
L5653	ADDITIONS TO LOWER EXTREMITY, KNEE DISARTICULATION, EXPLANDABLE WALL SOCKET
L5654	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5655	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5656	ADDITION TO LOWER EXTEREMITY, SOCKET INSERT, KNEE DISARTICULATION, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5658	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5660	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, SILICONE GEL OR EQUAL
L5661	ADDITION OT LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER SYMES
L5662	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE, SILICONE GEL OR EQUAL
L5663	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, KNEE DISARTICULATION, SILICONE GEL OR EQUAL
L5664	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE, SILICONE GEL OR EQUAL

PROSTHETICS AND ORTHOTICS

L5665	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER, BELOW KNEE
L5666	ADDITION TO LOWER EXTREMITY, BELOW KNEE, CUFF SUSPENSION
L5668	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED DISTAL CUSHION
L5670	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ("PTS" OR SIMILAR)
L5672	ADDITION TO LOWER EXTREMITY, BELOW KNEE, REMOVABLE MEDIAL BRIM SUSPENSION
L5674	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LATEX SLEEVE SUSPENSION OR EQUAL, EACH
L5675	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LATES SLEEVE SUSPENSION OR EQUAL, HEAVY DUTY, EACH
L5676	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR
L5677	ADDTIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR
L5678	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR
L5680	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER NON-MOLDED
L5682	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, GLUTEAL/ISCHIAL, MOLDED
L5684	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FORK STRAP
L5686	ADDITION TO LOWER EXTREMITY, BELOW KNEE, BACK CHECK (EXTENSION CONTROL)
L5688	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, WEBBING

PROSTHETICS AND ORTHOTICS

L5690	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, PADDED AND LINED
L5692	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, LIGHT
L5694	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, PADDED AND LINED
L5696	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC JOINT
L5697	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC BAND
L5698	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, SILESIAN BANDAGE
L5699	ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS
L5700	ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT
L5701	ALL LOWER EXTREMITY PROSTHESES, SAFE FOOT
L5702	ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT
L5703	ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE, STEN, CARBON COPY II OR EQUAL)
L5704	ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT (GREISSINGER OR EQUAL)
L5705	ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM
L5706	ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT
L5707	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT

PROSTHETICS AND ORTHOTICS

L5709	ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT ('MCP' OR EQUAL)
L5710	ADDITION, EXOSKELETAL KNEE-SHIN SYTEM, SINGLE AXIS, MANUAL LOCK
L5711	ADDITONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL
L5712	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STAND PHASE CONTROL (SAFETY KNEE)
L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL
L5716	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK
L5718	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRACTION SWING, AND STANCE PHASE CONTROL
L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
L5726	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, EXTERNAL JOINTS FLUID SWING PHASE CONTROL
L5728	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEUMATIC SWING PHASE CONTROL
L5785	ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL
L5790	ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANTIUM, CARBON FIBER OR EQUAL)
L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)

PROSTHETICS AND ORTHOTICS

L5810	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK
L5811	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL
L5812	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGEL AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)
L5814	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL
L5816	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK
L5818	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL
L5822	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
L5824	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
L5828	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
L5830	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PHEUMATIC/HYDRAPNEUMATIC SWING PHASE CONTROL
L5850	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, KNEE EXTENSION ASSIST
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ALIGNABLE SYSTEM
L5920	ADDITION ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
L5950	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
L5960	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)

PROSTHETICS AND ORTHOTICS

L5999	UNLISTED PROCEDURES FOR LOWER EXTREMITY PROSTHESIS
L6000	PARTIAL HAND, ROBIN-AIDS, THUMB REMAINING (OR EQUAL)
L6010	PARTIAL HAND, ROBIN-AIDS, LITTLE AND/OR RING FINGER REMAINING (OR EQUAL)
L6020	PARTIAL HAND, ROBIN-AIDS, NO FINGER REMAINING (OR EQUAL)
L6050	WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD
L6055	WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD
L6100	BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD
L6110	BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)
L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF
L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF
L6200	ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE FOREARM
L6205	ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM
L6250	ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM
L6300	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM
L6310	SHOULD DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)
L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM

PROSTHETICS AND ORTHOTICS

L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
L6370	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)
L6380	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITAL RIGID DRESSING, INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, WRISTS DISARTICULATION OR BELOW ELBOW
L6382	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING ALINGMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, ELBOW DISARTICULATION OR ABOVE ELBOW
L6384	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC
L6386	IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT
L6388	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ONLY
L6400	BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6450	ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6500	ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6550	SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6570	INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6580	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL

PROSTHETICS AND ORTHOTICS

L6582	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6584	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OF EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL
L6586	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OR EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6588	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGE WALL PLASTIC SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL
L6590	PREPARATORY, SHOULD DISARTICULATION OR INTERSCAPULAR THRACIC, SINGLE WALL SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6600	UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR
L6605	UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR
L6610	UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR
L6615	UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT
L6620	UPPER EXTREMITY ADDITION, FLEXION-FRICTION WRIST UNIT
L6623	UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST UNIT WITH LATCH
L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK
L6628	UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER, OTTO BOCK OR EQUAL
L6629	UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLING PIECE, OTTO BOCK OR EQUAL

PROSTHETICS AND ORTHOTICS

L6630	UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST
L6632	UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE, EACH
L6635	UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW
L6637	UPPER EXTREMITY ADDITION, NUDGE CONTROL ELBOW LOCK
L6640	UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR
L6641	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE
L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE
L6645	UPPER EXTREMITY ADDITION, SHOULDER FLEXION-ABDUCTION JOINT, EACH
L6650	UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH
L6655	UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA
L6660	UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL CABLE
L6665	UPPER EXTREMITY ADDITION, TEFLON, OR EQUAL, CABLE LINING
L6670	UPPER EXTREMITY ADDITION, HOOK TO HANK, CABLE ADAPTER
L6672	UPPER EXTREMITY ADDITION, HARNESS, CHEST OR SHOULDER, SADDLE TYPE
L6675	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ("8") EIGHT TYPE, FOR SINGLE CONTROL
L6676	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ("8") EIGHT TYPE, FOR DUAL CONTROL
L6680	UPPER EXTREMITY ADDITION, TEST SOCKET, WRIST DISARTICULATION OR BELOW ELBOW
L6682	UPPER EXTREMITY ADDITION, TEST SOCKET, ELBOW DISARTICULATION OR ABOVE ELBOW
L6684	UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTICULATION OR INTERSCAPULAR THRACIC

PROSTHETICS AND ORTHOTICS

L6686	UPPER EXTREMITY ADDITION, SUCTION SOCKET
L6687	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, BELOW ELBOW
L6688	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, ABOVE ELBOW
L6689	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, SHOULDER DISARTICULATION
L6690	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, INTERSCAPULAR-THORACIC
L6691	UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH
L6700	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #3
L6705	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5
L6710	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5X
L6715	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5XA
L6720	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #6
L6725	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7
L6730	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7LO
L6735	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8
L6740	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8X
L6745	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #88X
L6750	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10P
L6755	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10X
L6760	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10AW
L6765	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #12P
L6770	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #99X

PROSTHETICS AND ORTHOTICS

L6775 TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #555

L6780 TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #SS555

L6785 TERMINAL DEVICE, HOOK, DORRANCE OR EQUAL, MODEL #SSS555

L6790 TERMINAL DEVICE, HOOK-ACCU HOOK, OR EQUAL

L6795 TERMINAL DEVICE, HOOK-2 LOAD, OR EQUAL

L6800 TERMINAL DEVICE, HOOK-APRL VC, OR EQUAL

L6805 TERMINAL DEVICE, MODIFIER WRIST FLEXION UNIT

L6806 TERMINAL DEVICE, HOOK, TRS, GRIP, VC

L6807 TERMINAL DEVICE, HOOK, TRS, ADEPT, CHILD, VC

L6808 TERMINAL DEVICE, HOOK, TRS, ADEPT, INFANT, VC

L6809 TERMINAL DEVICE, HOOK, TRS, SUPER SPORT, PASSIVE

L6810 TERMINAL DEVICE, PINCHER TOOL, OTTO BOCK OR EQUAL
HANDS

L6825 TERMINAL DEVICE, HAND, DORRANCE, VO

L6830 TERMINAL DEVICE, HAND, APRL, VC

L6835 TERMINAL DEVICE, HAND, SIERRA, VO

L6840 TERMINAL DEVICE, HAND, BECKER IMPERIAL

L6845 TERMINAL DEVICE, HAND, BECKER LOCK GRIP

L6850 TERMINAL DEVICE, HAND, BECKER PLYLITE

L6855 TERMINAL DEVICE, HAND, ROBIN-AIDS, VO

L6860 TERMINAL DEVICE, HAND, ROBIN-AIDS, VO SOFT

L6865 TERMINAL DEVICE, HAND, PASSIVE HAND

PROSTHETICS AND ORTHOTICS

L6867	TERMINAL DEVICE, HAND, DETROIT INFANT HAND (MECHANICAL)
L6868	TERMINAL DEVICE, HAND, PASSIVE INFANT HAND (STEEPER, HOSMER OR EQUAL)
L6869	TERMINAL DEVICE, HAND, PASSIVE INFANT HAND HOSMER OR EQUAL
L6870	TERMINAL DEVICE, HAND, CHILD MITT
L6872	TERMINAL DEVICE, HAND, NYU CHILD HAND
L6873	TERMINAL DEVICE, HAND, MECHANICAL INFANT HAND STEEPER OR EQUAL
L6875	TERMINAL DEVICE, HAND, BOCK, VC
L6880	TERMINAL DEVICE, HAND, BOCK, VO
L6890	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, PRODUCTION GLOVE
L6890	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, CUSTOM GLOVE
L6900	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, THUMB OR LINE FINGER REMAINING
L6905	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, MULTIPLE FINGERS REMAINING
L6910	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, NO FINGERS REMAINING
L6915	HAND RESTORATION (SHADING AND MEASUREMENTS INCLUDED), REPLACEMENT GLOVE FOR ABOVE
L6920	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL, SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6925	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL, ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6930	BELOW, ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE

PROSTHETICS AND ORTHOTICS

L6935	BELOW, ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6940	ELBOW DISARTICULATION, EXTERNAL POWER, MOLD INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLD INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6950	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING BELOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6955	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING ELBOW, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6960	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6965	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6970	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE

PROSTHETICS AND ORTHOTICS

L6975	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL,SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L7010	ELECTRONIC HAND, OTTO BOCK, STEEPER OR EQUAL, SWITCH CONTROLLED
L7015	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7020	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, SWITCH CONTROLLED
L7025	ELECTRONIC HAND, OTTO BOCK, MYOELECTRONICALLY CONTROLLED
L7030	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7035	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, MYOELECTRICALLY CONTROLLED
L7040	PREHENSILE ACTUATOR, HOSMER OR EQUAL, SWITCHED CONTROLLED
L7045	ELECTRONIC HOOK, CHILD, MICHIGAN OR EQUAL, SWITCH CONTROLLED
L7160	ELECTRONIC ELBOW, BOSTON OR EQUAL, SWITCH CONTROLLED
L7165	ELECTRONIC ELBOW, BOSTON OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED
L7180	ELECTRONIC ELBOW, UTAH OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7185	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7190	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7260	ELECTRONIC WRIST ROTATOR, OTTO BOCK OR EQUAL

PROSTHETICS AND ORTHOTICS

L7261	ELECTRONIC WRIST ROTATOR, FOR UTAH ARM
L7266	SERVO CONTROL, STEEPER, OR EQUAL
L7272	ANALOGUE CONTROL, UNB OR EQUAL
L7274	PROPORTIONAL CONTROL, 12 VOIT, UTAH OR EQUAL
L7360	SIX VOLT BATTERY, OTTO BOCK OR EQUAL, EACH
L7362	BATTERY CHARGER, SIX VOLT BATTERY, OTTO BOCK OR EQUAL
L7364	TWELVE VOLT BATTERY, OTTO BOCK OR EQUAL, EACH
L7366	BATTERY CHARGER, TWELVE VOLT BATTERY, UTAH OR EQUAL
L7499	UNLISTED PROCEDURES FOR UPPER EXTREMITY PROSTHESIS
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE
L7510	REPAIR PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L8000	BREAST PROSTHESIS, MASTECTOMY BRA
L8010	BREAST PROSTHESIS, MASTECTOMY SLEEVE
L8020	BREAST PROSTHESIS, MASTECTOMY FORM
L8300	TRUSS, SINGLE WITH STANDARD PAD
L8310	TRUSS, DOUBLE WITH STANDARD PADS
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER PAD
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL PAD
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH
L8420	PROSTHETIC SOCK, WOOL, BELOW KNEE, EACH
L8430	PROSTHETIC SOCK, WOOL, ABOVE KNEE, EACH

PROSTHETICS AND ORTHOTICS

L8435	PROSTHETIC SOCK, WOOL, UPPER LIMB, EACH
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH
L8465	PROSTHETIC SHRINGER, UPPER LIMB, EACH
L8470	STUMP SOCK, SINGLE PLY, FITTING, BELOW KNEE, EACH
L8480	STUMP SOCK, SINGLE PLY, FITTING, ABOVE KNEE, EACH
L8499	UNLISTED PROCEDURES FOR MISCELLANEOUS PROSTHEIC SERVICES
L9999	SALES TAX, ORTHOTIC/PROSTHETIC/OTHER
V2620	PROSTHETIC, EYE, GLASS, STOCK
V2621	PROSTHETIC, EYE, PLASTIC, STOCK
V2622	PROSTHETIC, EYE, GLASS, CUSTOM
V2623	PROSTHETIC, EYE, PLASTIC, CUSTOM

CAPPED RENTAL

E0145	WALKER, WHEELED, WITH SEAT AND CRUTCH ATTACHMENTS
E0146	WALKER, WHEELED, WITH SEAT
E0165	COMMODE CHAIR, STATIONARY, WITH DETACHABLE ARMS
E0166	COMMODE CHAIR, MOBILE, WITH DETACHABLE ARMS
E0180	PRESSURE PAD, ALTERNATING WITH PUMP
E0181	PRESSURE PAD, ALTERNATING WITH PUMP, HEAVY DUTY
E0182	PUMP FOR ALTERNATING PRESSURE PAD
E0183	FLOTATION PAD FOR WHEELCHAIR
EO190	DECUBITUS CARE MATTRESS, INCLUDES FLOTATION OR GEL MATTRESS
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAID FOR WHEELCHAIR
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER
E0235	PARAFFIN BATH UNIT, PORTABLE
E0236	PUMP FOR WATER CIRCULATING PAD
E0250	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS
E0251	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS
E0252	HOSPITAL BED, FIXED HEIGHT, WITH MATTRESS
E0255	HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO WITH MATTRESS
E0260	HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS
E0265	HOSPITAL BED, TOTAL ELECTRIC WITH SIDERAILS, (HEAD, FOOT AND HEIGHT ADJUSTMENTS, WITH MATTRESS)
E0266	HOSPITAL BED, WITH SIDE RAILS, TOTAL ELECTRIC HEAD, FOOT AND HEIGHT ADJUSTMENTS, WITHOUT MATTRESS

CAPPED RENTAL

E0305	BED SIDE RAILS, HALF LENGTH
E0456	CHEST CURASS, WITH PUMP
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL
E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIVERY, E.G., CASCADE
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN
E0606	POSTURAL DRAINAGE BOARD MONITORING EQUIPMENT (E0607 - E0619)
E0608	APNEA MONITOR
E0630	PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING
E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL (LYMPHEDEMA PUMP) WITH CALIBRATED GRADIENT PRESSURE
E0668	PNEUMATIC APPLIANCE FOR USE WITH SEGMENTAL PNEUMATIC COMPRESSOR, ARM
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT, NON-CLINICAL MODEL
E0749	OSTEOGENESIS STIMULATOR (SURGICALLY IMPLANTED)
E0781	EXTERNAL AMBULATORY INFUSION PUMP WITH ADMINISTRATIVE EQUIPMENT
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR

CAPPED RENTAL

E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE
E0946	FRACTURE, FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED, (E.G. BALKEN, 4 POSTER)
E0958	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE
E0968	COMMODE SEAT, WHEELCHAIR
E1030	ROLLABOUT CHAIR, WITHOUT ARMS
E1035	GERIATRIC CHAIR
E1036	POSITIONING CHAIR (SUBMIT BRAND NAME, MODEL NUMBER AND SPECIFICATIONS)
E1040	ROLLABOUT CHAIR, WITH FIXED OR REMOVABLE ARMS
	WHEELCHAIR - FULLY-RECLINING
E1050	FULLY-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1060	FULLY-RECLINING WHEELCHAIR, DETACHBLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1070	FULLY-RECLINING WHEELCHAIR, DETACHBLE ARMS, (DESK OR FULL LENGTH), SWING AWAY DETACHABLE FOOTREST
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1084	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1085	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS
E1086	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS
E1087	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1088	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS

CAPPED RENTAL

E1089	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST
E1090	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS
E1091	YOUTH WHEELCHAIR, ANY TYPE
E1092	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS DESK OF FULL LENGHT, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1093	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS DESK OR FULL LENGHT, SWING AWAY DETACHABLE FOOTRESTS
	WHEELCHAIR - SEMI-RECLINING
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1110	SEMI-RECLINGING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELVATING LEGREST
E1130	STANDARD WHEELCHAIR, FIXED FULL LENGTH ARMS, FIXED FOR FULL SWING AWAY DETACHABLE FOOTRESTS
E1140	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS
E1150	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1160	WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
	WHEELCHAIR-AMPUTEE
E1170	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1171	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, WITHOUT FOOTRESTS OR LEGRESTS
E1172	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) WITHOUT FOOTRESTS OR LEGRESTS

CAPPED RENTAL

E1180	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTRESTS
E1190	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1195	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1200	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTRESTS
	WHEELCHAIR-POWER
E1210	MOTORIZED WHEELCHAIR WITH MICROSWITCH CONTROL, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1211	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY, DETACHABLE ELEVATING LEG RESTS
E1212	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE FOOT RESTS
E1213	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY, DETACHABLE FOOT RESTS
	WHEELCHAIR - SPECIAL SIZE
E1221	WHEELCHAIR WITH FIXED ARM, FOOTRESTS
E1222	WHEELCHAIR WITH FIXED ARM, ELEVATING LEGRESTS
E1223	WHEELCHAIR WITH DETACHED ARMS, FOOTRESTS
E1224	WHEELCHAIR WITH DETACHED ARMS, ELEVATING LEWRESTS
E1225	SEMI-RECLINING BACK FOR CUSTOMIZED WHEEL CHAIR
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR POWER OPERATED VEHICLE
E1240	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS, (DESK OR FULL LENGTH) SWING AWAY DETACHABLE, ELEVATING LEGREST

CAPPED RENTAL

E1250	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE, FOOTREST
E1260	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ARMS, SWING AWAY DETACHABLE, FOOTREST
E1270	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE, ELEVATING LEGREST
	WHEELCHAIR - HEAVY DUTY
E1280	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST
E1285	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY
E1290	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS ELEVATING LEGREST
E1310	WHIRLPOOL, NONPORTABLE (BUILT-IN TYPE)

OXYGEN

* Q0036	OXYGEN CONCENTRATOR, HIGH HUMIDITY
* Q0037	OXYGEN AND WATER VAPOR ENRICHING SYSTEM
** Q0038	OXYGEN CONTENTS, GASEOUS PER UNIT (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED; 1 UNIT = 50 CUBIC FT.)
** Q0039	OXYGEN CONTENTS, LIQUID PER UNIT (FOR USE WITH OWNED STATIONARY LIQUID SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE LIQUID SYSTEM ARE OWNED; 1 UNIT = 10 LBS.)
** Q0040	PORTABLE OXYGEN CONTENTS, GASEOUSPER UNIT (FOR USE WITH OWNED PROTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS SYSTEM IS USED; 1 UNIT = 5 CUBIC FT.)
** Q0041	PORTABLE OXYGEN CONTENTS, LIQUID, PER UNIT, (FOR USE ONLY WITH OWNED PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY LIQUID SYSTEM IS USED; 1 UNIT = 1 LB.)
* Q0042 (Rental Only)	STATIONARY COMPRESSED GAS SYSTEM RENTAL, INCLUDES (Rentals Only) CONTENTS (PER UNIT), REGULATOR WITH FLOW GAUGE, HIMIDIFIER, NEBULIZER, CANNULA OR MASK AND TUBING; 1 UNIT = 50 CUBIC FT.)
* Q0043 (Rental Only)	STATIONARY LIQUID OXYGEN SYSTEM RENTAL, INCLUDES (Rentals Only) CONTENTS (PER UNIT), USE OF RESERVOIR, CONTENTS INDICATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK AND TUBING; 1 UNIT OF CONTENTS = 10 LBS.)
E0425 (Purchase)	STATIONARY COMPRESSED GAS SYSTEM, INCLUDES REGULATOR WITH FLOW GAUGE, HUMIDIFIER, CANNULA OR MASK AND TUBING
E0430	PORTABLE GASEOUS OXYGEN SYSTEM INCLUDES REGULATOR WITH FLOW GAUGE, HUMIDIFIER, CANNULA OR MASK AND TUBING

OXYGEN

E0435	OXYGEN SYSTEM, LIQUID, PORTABLE, INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOW HUMIDIFIER
**** E0440 (Purchase)	OXYGEN SYSTEM, LIQUID, STATIONARY, INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING
*** E0455	OXYGEN TENT, EXCLUDING GROUP OR PEDIATRIC TENTS
*** E0555	HUMIDIFER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
*** E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
*** E1351	CANNULA
*** E1352	TUBING, UNSPECIFIED LENGTH
*** E1353	REGULATOR
*** E1354	MOUTH PIECE
*** E1371	FACE TENT
*** E1374	VARIABLE CONCENTRATOR MASK
E1400	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MANIMUM FLOW RATE DOES NOT EXCEED 2 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1401	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 2 LITERS PER MINUTE, DOES NOT EXCEED 3 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION

OXYGEN

E1402	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 3 LITERS PER MINUTE, DOES NOT EXCEED 4 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1403	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 4 LITERS PER MINUTE, DOES NOT EXCEED 5 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1404	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 5 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION

*	FOR BILLING GAS AND LIQUID SYSTEM RENTALS AND CONCENTRATOR RENTALS OR PURCHASE
**	FOR MONTHLY BILLING OF CONTENTS USED WITH PURCHASED GAS OR LIQUID OXYGEN DELIVERY SYSTEMS (I.E., NO STATIONARY SYSTEM IS BEING RENTED)
***	FOR BILLING OF REPLACEMENT ITEMS FOR PURCHASED DELIVERY SYSTEMS
****	FOR BILLING OF SYSTEM PURCHASES ONLY

NEED PRESCRIPTION BEFORE DELIVERY

E0180	PRESSURE PAD, ALTERNATING WITH PUMP
E0181	PRESSURE PAD, ALTERNATING WITH PUMP, HEAVY DUTY
E0182	PUMP FOR ALTERNATING PRESSURE PAD
E0183	FLOTATION PAD FOR WHEELCHAIR
E0184	FLOTATION MATTRESS, DRY
E0185	DECUBITUS CARE PAD, FLOTATION OR GEL WITH FOAM LEVELING PAD
E0188	SYNTHETIC SHEEPSKIN PAD
E0189	LAMBSWOOL, SHEEPSKIN PAD, ANY SIZE
E0190	DECUBITUS CARE MATTRESS, INCLUDES FLOTATION OR GEL MATTRESS
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAD FOR WHEELCHAIR
E0195	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT
E0620	SEAT LIFT CHAIR, MOTORIZED TO ASSIST PATIENT IN STANDING AND SITTING
E0720	TENS, TWO LEAD, LOCALIZED STIMULATION
E0730	TENS, FOUR LEAD, LARGER, AREA/MULTIPLE NERVE STIMULATION
E1230	POWER OPERATED VEHICLE (3 WHEEL NONHIGHWAY) INDICATE BRAND NAME AND MODEL NUMBER

CHAPTER IV

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400. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) SERVICES

Section 933 of P.L. 96-499 (the Omnibus Reconciliation Act of 1980) added to the scope of benefits available to beneficiaries under Part B, certain services furnished by CORFs.

A CORF is recognized as a provider of services, reimbursable on the basis of its reasonable costs. To participate as a CORF, you must provide at least the following three services:

- o Physicians' services;
- o Physical therapy; and
- o Social or psychological services.

In addition to this basic package of services, you may furnish and receive reimbursement for as many of the other items and services listed in §401A as you wish.

Under regulations which implement the amendment, the facility must have adequate space and equipment necessary to provide any of the services you elect to provide. Additionally, in order to accept a patient, you must be able to provide all of the services required by the patient, as established in the plan of treatment. If the CORF does not have personnel to provide the service, you may arrange for the services to be provided at the CORF, as needed, by outside practitioners. Reimbursement will be made by assigned intermediaries acting in the role of Part B carriers.

CORF services are subject to the Medicare Part B deductible and coinsurance provisions; i.e., you may bill the beneficiary only the unmet portion of the deductible and 20 percent of your customary charges for covered services.

In enacting this legislation, the Congress indicated its concern that although rehabilitation services were covered in various settings under the provisions of the existing law, there was no provision that would permit the beneficiary to receive a variety of rehabilitation services at a central location. Section 933 provides coverage for a broad array of rehabilitation services furnished on an outpatient basis in a coordinated fashion by a CORF.

401. COVERED CORF SERVICES AND NONCOVERED SERVICES

A. Covered CORF Services.--The following are covered CORF services:

o Physicians' services related to administrative functions;

o Physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

o Social and psychological services;

o Nursing care provided by or under the supervision of a registered professional nurse;

- Prosthetic and orthotic devices, including testing, fitting, or training in the use of such devices;

- Drugs and biologicals which cannot be self-administered;

- Supplies, appliances, and equipment, including the purchase or rental of DME from the CORF; and

- A single home visit to evaluate the potential impact of the home environment on the rehabilitation goals.

B. Noncovered Services.--The statute specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service if provided to a hospital patient. This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care. This provision merely requires that the service, if otherwise covered, would be covered if provided in a hospital. Accordingly, coverage determinations for CORF services will be based on established coverage guidelines.

CORF services are not covered if not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. Thus, there must be potential for restoration or improvement of lost or impaired functions. For example, services involving repetitive services that do not require the skilled services of nurses or therapists, such as maintenance programs or general conditioning or ambulation, are not covered. These services could be performed in the patient's residence by nonmedical personnel such as family members. It is not reasonable and necessary for such services to be performed in an ambulatory care setting by CORF personnel.

402. PROVISION OF SERVICES

A. Place of Treatment.--In general, all services must be furnished on the premises of the CORF. The only exceptions are the home evaluation (see §401A) and, effective December 22, 1987, physical therapy, occupational therapy, and speech pathology services. There is no restriction on where these services may be furnished. They may be covered if furnished pursuant to the plan of treatment, and they do not duplicate services for which payment has otherwise been made under Medicare.

You must clearly identify each service performed off the premises of the facility so that your intermediary can easily differentiate between services provided at the facility and elsewhere. (See §318, Item 94.)

B. Personnel Qualification Requirements.--Services must be furnished or supervised by personnel who meet the requirements in HCFA regulations 42 CFR 485.70.

C. Services Furnished Under Arrangements.--CORF services provided under arrangements are subject to the provisions of §202.

D. Referral for Treatment.—To become a patient of a CORF, the beneficiary must be under the care of a physician who certifies that the beneficiary needs skilled rehabilitation services.

The referring physician must advise the CORF of the beneficiary's medical history, current diagnosis and medical findings, desired rehabilitation goals, and any contraindications to specific activity or intensity of rehabilitation services.

E. Plan of Treatment.—CORF services must be furnished under a written plan of treatment established by a physician. The physician may be either a physician associated with the CORF, or the referring physician if he or she provides a detailed plan of treatment that meets the following requirements.

The plan of treatment must contain the diagnosis, the type, amount, frequency and duration of services to be performed, and the anticipated rehabilitation goals.

The plan of treatment should be sufficiently detailed to permit an independent evaluation of the patient's specific need for the indicated services and of the likelihood that he or she will derive meaningful benefit from them.

The plan of treatment must be reviewed by the CORF physician at least once every 60 days. Following the review, the physician should certify that the plan of treatment is being followed and that the patient is making progress in attaining the established rehabilitation goals. When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends with respect to that aspect of the plan of treatment.

403 Specific CORF Services

403.1 Physicians' Services.

Certain administrative services provided by the physician associated with the CORF are considered CORF services and are reimbursable to the CORF. These services include: examinations for the purpose of establishing and reviewing the plan of treatment, consultation with and medical supervision of non-physician staff, and other medical and facility administration activities.

Physicians' diagnostic and therapeutic services furnished to an individual patient are not CORF physicians' services. They are regular physicians' services, billable to the Part B carrier. The claims form must be clearly annotated to show the CORF as the place of treatment. Payment for these services is made on a reasonable charge basis subject to the same limitations applicable to physicians' services furnished in outpatient hospital settings.

403.2 Physical Therapy Services.

The coverage guidelines in §205.5 apply to physical therapy services provided by CORFs. Note that under those guidelines, maintenance physical therapy, i.e., repetitive services required to maintain a level of functioning, would not be covered. However, the establishment of a maintenance program for a patient whose restoration potential has been reached would be a covered service. This would include examinations, evaluations of the patient's condition, preparation of the maintenance program, and the training of nonskilled persons to carry out the program.

403.3 Occupational Therapy Services

A. General.--Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

1. The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

2. The selection and teaching of task-oriented therapeutic activities designed to restore physical function,, e.g., use of woodworking activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns;

3. The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;

4. The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function, e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

5. The teaching of compensatory technique to improve the level of independence in the activities of daily living, e.g., teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a stroke patient new techniques to enable him to perform feeding, dresssing, and other activities as independently as possible;

6. The designing, fabricating, and fitting of orthotic and self- help devices, e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed himself independently; and

7. Vocational and prevocational assessment and training.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. ("General supervision" requires initial direction and periodic inspection of the actual activity; however, the supervisor need not always be physically present or on the premises when the assistant is performing services.)

B. Coverage Criteria.--To constitute covered occupational therapy for Medicare purposes the services furnished to a beneficiary must be (1) prescribed by a physician, (2) performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist, and (3) reasonable and necessary for the treatment of the individual's illness or injury.

Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would thus be excluded from coverage by §1862(a)(1). Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be covered even though the expectation may not be realized. However, in such situations the services would be covered only up to the time at which it would have been reasonable to conclude that the patient is not going to improve. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an occupational therapist or occupational therapy assistant will not be required in the carrying out of any activity and/or exercise program required to maintain function at the level to which it has been restored. Consequently, while the services of an occupational therapist in designing a maintenance program and making infrequent but periodic evaluation of its effectiveness would be covered, the services of an occupational therapist or occupational therapy assistant in carrying out the program are not considered reasonable and necessary for the treatment of illness or injury and such services are excluded from coverage under §1862(a)(1).

Generally speaking, occupational therapy is not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bedrest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Accordingly, occupational therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury and the services would be excluded from coverage by §1862(a)(1).

Occupational therapy may also be required for a patient with a specific diagnosed psychiatric illness. Where such services are required they would be covered, assuming the coverage criteria set forth above are met. However, it should be noted that where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Rather, such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient, patient motivation being an appropriate and inherent function of all health disciplines which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist or occupational therapy assistant are not required, an occupational therapy program for such individuals would not be considered reasonable and necessary for the treatment of an illness or injury, and services furnished under such a program would be excluded from coverage by §1862(a)(1).

As indicated, occupational therapy includes vocational and prevocational assessment and training. When services provided by an occupational therapist and/or assistant are related solely to specific employment opportunities, work skills or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are excluded from coverage under the program by §1862(a)(1).

C. Supplies.--Occupational therapy frequently necessitates the use of various supplies, e.g., looms, ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

403.4 Speech Pathology Services. Speech pathology services are subject to the guidelines in §205.6.

Services related to congenital speech difficulties, such as stuttering or lisping, would not be covered unless such services are incident to the treatment of otherwise covered CORF services.

Although in other outpatient settings, a speech pathologist is permitted to establish a plan of treatment, this is not the case with CORF services. Under the statute, all CORF services must be provided under a plan established by a physician. However, as with other specialties, it is expected that the physician will rely heavily on advice from the speech pathologist.

403.5 Respiratory Therapy Services

A. Definition.--Respiratory therapy (respiratory care) is defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring (as defined in §403.5B.4.) of patients with deficiencies and abnormalities of cardiopulmonary function.

Respiratory therapy services include but are not limited to:

1. The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to: a) establishment and maintenance of artificial airways; b) ventilator therapy and other means of airway pressure manipulation; c) precise delivery of oxygen concentration; and d) techniques to aid removal of secretions from the pulmonary tree.

2. The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and such equipment as resuscitators and ventilators;

3. Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning;

4. Diagnostic tests for evaluation by a physician, e.g., pulmonary function tests, spirometry, and blood gas analyses;

5. Pulmonary rehabilitation techniques which include: a) exercise conditioning; b) breathing retraining; and c) patient education regarding the management of the patient's respiratory problems; and

6. Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services.

Such services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel.

To qualify for reimbursement under Medicare, such therapy (1) must qualify as a covered service, and (2) must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

B. Guidelines for Applying Coverage Criteria.--While there are many conditions for which respiratory therapy may be indicated, for Medicare purposes coverage of respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for such services.

The following discussion illustrates some examples of the application of the Medicare guidelines.

1. Preoperative Bronchial Hygiene Therapy.--Bronchial hygiene therapy furnished on a routine basis to preoperative patients would be presumed not to be reasonable and necessary and would, therefore, be excluded from coverage under §1862(a)(1). Circumstances under which preoperative bronchial hygiene therapy may be reasonable and necessary would include those situations when it is furnished to patients with pulmonary disease which by itself requires such therapy.

2. Postoperative Bronchial Hygiene Therapy.--Routine procedures such as deep breathing and cough instruction, frequent repositioning and early ambulation should provide for adequate bronchial hygiene in the majority of postoperative patients. Therefore, bronchial hygiene therapy services, in addition to those cited above, when furnished on a routine basis to most postoperative patients would be presumed not to be necessary and would be excluded from coverage under §1862(a)(1).

3. Oxygen Therapy.—Oxygen therapy is administered utilizing many devices ranging from the simple nasal cannula to progressively complex techniques providing controlled oxygen concentrations. Such devices are usually applied, maintained, and monitored by respiratory therapists and technicians. These services will be covered provided the need and the effectiveness is documented.

The goal of oxygen therapy is to maintain adequate tissue and cell oxygenation while trying to minimize the danger of oxygen toxicity. Periodic measurement of the arterial PO_2 or oxygen saturation at rest and/or during exercise aids in determining the appropriate amount of oxygen to be administered, and is necessary until the patient has achieved a stable status.

4. Monitoring Services.—The term monitoring as used in the context of this instruction means: periodic checking of the equipment in actual use for the purpose of ascertaining that it is functioning properly (see 3. above); monitoring the individual patient's condition for purposes of assuring that the patient is receiving the proper mixtures of medical gases, mists and aerosols (see §403.5A.2.), and periodic checking of the patients for the purposes described in §403.5A.6. Checking solely to determine if a patient is using oxygen and the amount of oxygen used is not considered the type of monitoring that requires specialized training or skills, and therefore is not a covered respiratory therapy service.

C. Patient Education Programs.—Instructing a patient in the use of equipment, breathing exercises, etc., may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist or technician. While patient activities involved in the management of respiratory problems are not ordinarily of such complexity as to warrant a structured or formal patient education program, there may be instances where such a program may be appropriate; e.g., where the patient will experience significant behavior modification or rely on mechanical support after discharge from the hospital. However, the content of structured or formal education programs must be reasonable and necessary, that is, such programs should meet but not exceed the needs of patients. For Medicare purposes, the provision of information that is over and beyond that ordinarily provided during the course of a treatment (e.g., extensive theoretical background in the pathology, etiology, and psysiological effects of the disease) is not considered reasonable and necessary to the management and treatment of illnesses.

403.6 Prosthetic and Orthotic Devices. Prosthetic devices, other than dental devices and renal dialysis machines, are covered CORF services. Prosthetic devices are defined as devices that replace all or part of an internal body organ or external body member (including contiguous tissue), or that replace all or part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Coverage of a prosthetic device includes all services necessary for formulating its design, material, and component selection; measurement, fittings, static and dynamic alignments; and instructing the patient in its use. Such coverage is included as an integral part of the fabrication of the device.

Orthotic devices are those orthopedic appliances or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. As with prosthetic devices, the coverage of an orthosis includes its design, materials, measurements, fabrications, testing, fitting, or training in the use of the orthosis.

403.7 Social Services. Social services are covered CORF services if they are included in the plan of treatment and contribute to the improvement of the individual's condition. Such services include:

A. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the CORF.

B. Assessment of the relationship of the patient's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from the CORF.

C. Counseling and referral for casework assistance in resolving problems in these areas.

403.8 Psychological Services. Covered services include:

A. Assessment, diagnosis and treatment of the beneficiary's mental and emotional functioning as it relates to his or her rehabilitation.

B. Psychological evaluations of the individual's response to and rate of progress under the treatment plan.

C. Assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment.

Although everyone who has a serious illness or injury may suffer from some degree of anxiety, the coverage of psychological services should not automatically extend to every CORF patient. For example, diagnostic testing for a mental problem would be covered for a cardiac patient who exhibits excessive anxiety or fear following the acute phase of a cardiac problem. However, the routine testing or treatment of all cardiac rehabilitation patients for mental, psychoneurotic, or personality disorders would not be covered.

Family counseling services would be covered only where the primary purpose of that counseling is the treatment of the patient's condition; that is, when there is a need to observe the patient's interaction with family members or to assess the capability of family members to aid in the rehabilitation of the patient. Family counseling services that are primarily directed toward the treatment of a family member's problem with respect to the patient's condition are not covered.

403.9 Nursing Services. Nursing services provided by or under the supervision of a registered nurse are covered CORF services.

403.10 Drugs and Biologicals. Drugs and biologicals would be covered when they cannot be self-administered, are administered by or under the supervision of a physician or registered nurse, and are not otherwise excluded from Medicare coverage, such as most injections for immunization. Determinations on whether a drug or biological is of a type that cannot be self-administered should be based on the usual method of administration of the form of that drug or biological as furnished to the CORF patient.

Thus, when a patient is given tablets or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a patient is given an injection that is usually self-injected, such as insulin, this drug would be excluded from coverage unless administered in an emergency situation, such as a diabetic coma, or where, because of the patient's mental or physical condition, self-administration is impossible or unwarranted. However, if a patient receives an injection of a drug that is not usually self-injected and that is also available in oral form, that drug would not be subject to the self-administrable drug exclusion, since it is not self-administrable in the form in which it was furnished to the patient.

403.11 Supplies, appliances, and equipment. Covered services include:

A. Nonreusable supplies, such as oxygen, bandages, or ceramic tiles, used in the various therapeutic modalities.

B. Medical equipment and appliances for the use of patients at the facility.

C. Durable medical equipment (DME) for use outside the CORF, whether furnished at the CORF or delivered to the beneficiary's home. The beneficiary may obtain DME from the CORF or other DME supplier. See §404ff for the definition and related information concerning DME. Note that under those guidelines, DME is defined as equipment such as a wheelchair or walker that is primarily and customarily used to serve a medical purpose. Thus, exercise appliances and other self-help devices that can be used for general conditioning would not qualify as DME.

403.12 Home Environment Evaluation. One offsite service is permitted - a single home visit to evaluate the potential impact of the home environment on the rehabilitation goals. The purpose of the evaluation is to permit the plan of treatment to be tailored to take into account the patient's home environment. It is not intended that the Medicare program underwrite physical alterations to the home that would facilitate the patient's rehabilitation.

The home evaluation is not covered as a routine service for all CORF patients. It would be covered only if, in establishing or carrying out the plan of treatment, there is a clear indication that the home environment might adversely affect the patient's rehabilitation. Coverage is limited to the services of one professional who is selected by the CORF.

404. RENTAL AND PURCHASE OF DURABLE MEDICAL EQUIPMENT.

A participating provider of service may be reimbursed under Part B on a reasonable cost basis for durable medical equipment which it rents or sells to a beneficiary for use in his home if the following three requirements are met:

A. The equipment meets the definition of durable medical equipment (§ 404.1); and

B. The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his malformed body member (§ 404.2); and

C. The equipment is used in the patient's home (§ 404.6).

Payment may also be made under this provision for repairs, maintenance, and delivery of equipment as well as for expendable and nonreusable items essential to the effective use of the equipment subject to the conditions in § 404.3.

404.1 Definition of Durable Medical Equipment.-- For purposes of coverage under Part B, durable medical equipment is equipment which (1) can withstand repeated use, and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.

A. Durability.-- An item is considered durable if it can withstand repeated use; i.e., the type of item which could normally be rented. Medical supplies of an expendable nature such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and bags are not considered "durable" within the meaning of the definition. There are other items which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment.-- Medical equipment is equipment which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury.

1. Equipment Presumptively Medical.-- Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines and traction equipment presumptively constitute medical equipment.

2. Equipment Presumptively Nonmedical.-- Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under Medicare. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered durable medical equipment. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, and posture chairs, do not constitute medical equipment. Similarly, physical fitness equipment, e.g., an exercycle; first-aid or precautionary-type equipment, e.g., preset portable oxygen units; self-help devices, e.g., safety grab bars; and training equipment, e.g., speech teaching machines and braille training texts, are considered nonmedical in nature.

3. Special Exception Items.-- Specified items of equipment may be covered under certain conditions even though they do not meet the definition of durable medical equipment because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who has bed sores or there is medical evidence indicating that he is highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity (§ 404.2) for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use.

NOTE: The above items represent special exceptions and no extension of coverage to other items should be inferred.

404.2 Necessary and Reasonable.-- Although an item may be classified as durable medical equipment, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member.

404.3 Repairs, Maintenance, Replacement, and Delivery.-- Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required durable medical equipment which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part B. Since renters of equipment usually recover from the rental charge the expenses they incur with respect to maintaining in working order the equipment they rent out, separately itemized charges for repair, maintenance, and replacement of rented equipment are not covered.

A. Repairs.-- Repairs to equipment which a beneficiary is purchasing or already owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess.

B. Maintenance.-- Routine periodic servicing, such as testing, cleaning, regulating and checking of the beneficiary's equipment is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, would be covered as repairs. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

C. Replacement.-- Replacement of equipment which the beneficiary owns or is purchasing is covered in cases of loss or irreparable damage or wear and when required because of a change in the patient's condition.

D. Delivery.-- Reasonable costs for delivery of durable medical equipment whether rented or purchased are covered if the provider customarily makes separate charges for delivery and this is a common practice among the other local providers.

404.4 Coverage of Supplies and Accessories.-- Reimbursement may be made for supplies, e.g., oxygen, that are necessary for the effective use of durable medical equipment. Such supplies include those drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system.

When the beneficiary owns or is purchasing the equipment, reimbursement may be made for the replacement of essential accessories such as hoses, tubes, mouth pieces, etc.

404.5 Miscellaneous Issues Included in the Coverage of Equipment.-- Payment can be made for the purchase of durable medical equipment even though rental payments may have been made for prior months. This could occur where, because of a change in his condition, the beneficiary feels that it would be to his advantage to purchase the equipment rather than to continue to rent it. When such a situation occurs, the provider may deduct all or part of the rentals paid from the purchase price of the equipment.

A beneficiary may sell or otherwise dispose of equipment for which he has no further use, for example, because of recovery from the illness or injury which gave rise to the need for the equipment. (There is no authority for the program to repossess the equipment.) If after such disposal there is again medical need for similar equipment, payment can be made for the rental or purchase of that equipment.

However, where an arrangement is motivated solely by a desire to create artificial expenses to be met by Medicare and to realize a profit thereby, such expenses would not be covered under Medicare.

When payments stop because the beneficiary's condition has changed and the equipment is no longer medically necessary, he is responsible for the remaining noncovered charges. Similarly, when payments stop because the beneficiary dies, his estate is responsible for the remaining noncovered charges.

404.6 Definition of Beneficiary's Home.-- For purposes of rental and purchase of durable medical equipment, a beneficiary's home may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a beneficiary's home if it:

A. Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

B. Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in A or B above, he is not entitled to have payment made for rental or purchase of durable medical equipment since such an institution may not be considered his home.

404.7 Payment for Durable Medical Equipment.—

A. The Decision to Rent or Purchase.— A beneficiary may elect to rent an item of equipment rather than purchase it even though it may appear that purchase would be more economical for the program.

1. Rental Payments.-- Where a provider rents durable medical equipment to a beneficiary, the provider is reimbursed 80 percent of the reasonable cost of making the equipment available, less any unmet deductible. The provider must submit form HCFA-1483 for each month's rental charge. The patient is responsible to the provider for any unmet deductible and the monthly coinsurance.

2. Purchase of Equipment.-- When equipment is purchased, the following guidelines determine whether program payment is to be made in a lump sum or in periodic payments.

a. Lump-Sum Payment for Inexpensive Equipment.-- Payment for inexpensive equipment is made in a lump sum subject to the deductible and coinsurance when it is determined to be less costly or more practical to do so. Inexpensive equipment is any item of durable medical equipment for which the reasonable charge is $50 or less. A presumption is made that it is less costly and more practical to pay a lump sum for inexpensive equipment. However, this presumption would not apply where the estimated period of medical need is relatively short. For example, a walkerette (purchase price $47.50) rents for $5 a month. If the physician estimates that the item would be needed 4 months, it would be less costly to make four periodic payments than to pay a lump-sum amount based on the reasonable purchase price.

b. Periodic Payment.-- Where payment is not made in a lump sum,benefits are paid in monthly installments equivalent to the payment that would have been made had the equipment been rented. However, periodic payments are made only for the established period of medical necessity for the item or until the total program payments to the provider equal 80 percent of the estimated cost of the item, whichever comes first. The periodic payments are subject to the deductible and coinsurance provisions. While periodic payments are made monthly, a single payment can be made for periodic payments which have accrued.

B. Incurred Expenses for Durable Medical Equipment.-- The first month's expense for the rental of durable medical equipment is incurred as of the date of delivery of the equipment for purposes of crediting the deductible and reimbursement. Expenses for subsequent months are incurred on the same day of the month. Where equipment is purchased, the periodic monthly benefits are payable on the same basis. Submit claims as of the date expenses are incurred.

C. Establishing the Period of Medical Necessity.-- Generally, the period of time an item of durable medical equipment is considered to be medically necessary is based on the physician's estimate of the time that his patient needs the equipment.

405 Psychiatric Services Limitation.

A. Basis for Limitation—Section 1833(c) of the Act imposes a limitation on reimbursement under Part B for outpatient psychiatric treatment (i.e., treatment when the beneficiary is not a hospital inpatient). This provision limits the amount of a beneficiary's incurred expenses for those services that are recognized for any calendar year to the lesser of 62.50 percent of those expenses, or a fixed dollar amount as follows: $312.50 for any year before 1988; $562.50 for 1988; and $1,375 for any year after 1988. Payment for the incurred expenses, as limited, is subject to the Part B deductible and coinsurance.

Under previous Medicare regulations, the limitation had applied only to expenses incurred for services and supplies furnished by physicians. However, under the regulations which implement the CORF provision, the limitation also applies to CORF services furnished by physicians and nonphysicians for services related to the treatment of a psychiatric condition, i.e., mental, psychoneurotic, and personality disorders. The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual-Mental Disorders.

B. Application of the Limitation.—

1. The CORF psychiatric limitation is not a limit separate from the limitation on physician's outpatient psychiatric services. Physician outpatient services and CORF services for the treatment of mental, psychoneurotic and personality disorders are combined for purposes of the limitation.

2. The limitation applies only to therapeutic services and to follow-up diagnostic services performed to evaluate the treatment. It does not apply to initial psychiatric or psychological diagnostic testing and evaluation.

3. In applying the fixed dollar amount and 62.50 percent limitations to incurred expenses, the intermediary uses the customary charges for the CORF services. A carrier uses reasonable charges for physician services. The $312.50, $562.50, and $1,375 amounts represent 62.50 percent respectively of $500, $900, and $2,200. Therefore, $500, $900, and $2,200 are the maximum amount of customary charges for CORF psychiatric services, plus reasonable charges for outpatient physician psychiatric services, that are covered respectively in any year before 1988, in 1988, and in any year after 1988.

C. Computation.—To compute the CORF's reimbursement for services related to a psychiatric condition, an intermediary:

1. Ascertains the total accumulated covered reasonable charges for outpatient physicians' psychiatric services and covered customary charges for CORF psychiatric services previously processed for the calendar year.

2. If the answer to 1. is $500 or more for any year before 1988, $900 or more for 1988, and $2,200 or more for any year after 1988, no further CORF reimbursement is available for the treatment of the patient's psychiatric condition on the current claim.

3. If the answer to 1. is less than $500 for any year before 1988, less than $900 for 1988, or less than $2,200 for any year after 1988, subtracts the amount in 1 from $500, $900, or $2,200, as applicable.

4. Determines the lesser of the customary charges for CORF psychiatric services on the current claim or the figure in 3. The amount so determined is the covered customary charges for CORF psychiatric services.

5. Multiplies the amount in 4. by .625. The result is the customary charges for CORF psychiatric services which, subject to Part B deductible and coinsurance, are reimbursable in the current claim.

D. Determining When the Limitation Applies.--

If the CORF services rendered are for both a psychiatric condition and one or more nonpsychiatric conditions, the intermediary separates the charges for the psychiatric aspects of treatment from the charges for the nonpsychiatric aspects. However, in any case in which the psychiatric and nonpsychiatric components are not readily distinguishable, the intermediary allocates the charges under the following rules.

1. Psychological services, whether furnished by psychologists or other personnel, are always subject to the limitation, regardless of the patient's diagnosis.

2. Physical therapy, respiratory therapy, speech therapy, and services furnished in connection with prosthetic and orthotic devices and the use of equipment and appliances related to these services, are not subject to the limitation.

3. For those services not specified in 1. and 2. above, such as occupational therapy, the intermediary determines the primary reason for the patient being referred to the CORF.

a. If the referral is primarily on the basis of a psychiatric condition, all such services are subject to the limitation except as specified in b. below.

b. If the referral is primarily on the basis of a diagnosis of Alzheimer's Disease (coded 331.0 in the International Classification of Diseases 9th Revision) or Alzheimer's or other disorders coded 290.XX in the American Psychiatric Association's Diagnostic and Statistical Manual—Mental Disorders, such services typically represent medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the benefit limitation. However, where a particular service provided a patient with such a diagnosis is primarily for psychological services as specified in 1. above, it is subject to the limitation.

c. If the referral is primarily on the basis of a physical condition, such services are not subject to limitation.

d. If the primary reason for referral is not clear, 50 percent of the customary charges are subject to the limitation.

E. Examples

1. Patient A is referred to the CORF for psychological evaluation and counseling. The plan of treatment includes services that are provided by a psychologist, a psychiatric nurse, a social worker, and an occupational therapist. Since all of the CORF services are furnished in connection with patient A's mental condition, all are subject to the psychiatric limitation.

2. Patient B, who has chronic schizophrenia, is injured in an accident resulting in amputation of his right hand and foot. Following a period of hospitalization, during which he is fitted with an artificial hand and foot, he is referred to the CORF for physical therapy, occupational therapy, and social services. Even though Patient B has a psychiatric condition, the CORF services are not furnished in connection with that condition and are not subject to the psychiatric limitation.

3. Same facts as Example 2, except that after treatment is initiated, it is determined that B's mental condition was aggravated by the results of the accident, and that he also needs psychological counseling and that the occupational therapy and social services should be continued but revised to also take into account his mental state.

The physical therapy still would not be subject to the psychiatric limitation. The psychological counseling would be subject. Because it cannot be clearly established whether the occupational therapy and social services are in connection with his physical or mental problem, 50 percent of the customary charges for these services would be applied to the psychiatric limitation.

CHAPTER V

MEDICAL REVIEW

Medical Review of Comprehensive Outpatient Rehabilitation Facility (CORF) Claims

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500. MEDICAL REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) CLAIMS

A. Purpose of the Medical Review.—To assure that the CORF services provided were:

- Covered CORF services as described in §§205.1-205.6 and §§400-405;

- Furnished to a patient who is under the care of a physician and who was referred by the physician certifying that the individual needs skilled rehabilitation services;

- Stipulated in a written plan of treatment which:

  - Was established and signed by a physician before treatment is began, and

  - Prescribes the type, amount, frequency and duration of the services to be furnished and indicates the diagnosis and anticipated specific rehabilitation goals

- Reasonable and necessary in relation to the patient's rehabilitation potential and progress as described in §§205.5 and 205.6.

NOTE: The plan of treatment must be reviewed at least every 60 days by a CORF physician. The reviewing physician must certify/recertify that the plan is being followed, the patient is making progress in attaining the rehabilitation goals and the treatment is having no harmful effects. Normally, the plan of treatment and certification/recertification are coordinated and may be contained in one document.

B. Documentation Requirements.—The intermediary is required to request medical information from you in order to perform the medical review. The guidelines for submitting the required medical information are as follows.

1. With the Initial Bill and Every 60 Days Therafter.—Supply a written plan of treatment signed by the physician including the information specified above, or the information from the plan of treatment provided on a form approved by the intemediary.

NOTE: Where a signed copy of the plan of treatment is not submitted and/or the certification/recertification statement and physician signature is not on the same document as the plan of treatment, retain the required information and signatures in your files to be available upon request.

2. With the Initial Bill.—Supply the pertinent medical history including date of onset or exacerbation of condition for which the services are being rendered and results of prior rehabilitation treatment (if any) for the same condition.

- A description of functional limitations and rehabilitation potential; and
- The results of initial evaluations by the CORF.

3. With Subsequent Claims for Services.—Submit the progress report and reevaluation findings with each billing. Daily notes are not required. Progress report and reevaluation findings are to reflect:

- Description of the treatment rendered;
- Description of the results of both subjective and objective tests and measures as compared to the initial or prior evaluation results;
- Description of the progress the patient is making toward obtaining the rehabilitation goals; and
- Statement by the physician as to why treatment should be continued if progress is not being made.

Medical Review of Part B Intermediary Outpatient Physical Therapy Bills

501. MEDICAL REVIEW (MR) OF PART B INTERMEDIARY OPT BILLS

A. General.—These instructions identify documentation requirements for OPT claims that you must submit to your intermediary for MR. It either selects OPT claims for MR by using the diagnostic edits identified in these instructions or reviews OPT claims at a 100 percent level. However, if it uses any of the diagnostic edits in Exhibit I, the visits and/or duration parameters may not be changed without approval from HCFA. Intermediaries may review claims in addition to those identified there. If they choose to select claims for review in addition to those identified in Exhibit I, or if they elect to review all OPT claims, they must secure prior approval from the RO and for the criteria used to select the additional claims. Conform to the documentation requirements in these instructions for all outpatient claims submitted to intermediaries (bill types, rehabilitation agency, public health agency, or clinic-74).

These criteria do not apply to inpatient PT services or to PT services provided under a home health plan of treatment or to PT services furnished by CORFs.

The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits. See Exhibit I. Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in these edits. The edits are only for selecting bills to review or for paying bills that meet Level I criteria without MR. They do not provide automatic coverage, up to these criteria. The criteria neither guarantee minimum coverage nor set maximum coverage limits.

B. Level I Review Process.—PT edits have been developed for a number of diagnoses selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled OPT. The edits do not specify every diagnosis which may require PT, and therefore, the fact that a given diagnosis does not appear in the edits does not create a presumption that OPT services are not necessary or are inappropriate. Claims may not be approved or denied by an intermediary at Level I for reasons of medical necessity. Claims that pass the edits in Exhibit I and any additional edits approved by the RO may be paid without being subjected to Level II MR.

Intermediaries evaluate bills at Level I based upon the following data which you must submit:

o Facility and Patient Identification - (facility name, patient name, provider number, HICN, age).

o Diagnosis - The primary diagnosis for which OPT services were rendered must be listed by ICD-9-CM code first; other Dx(s) applicable to the patient or that influence care follow.

o Duration - The total length of time OPT services have been rendered by you (in days) from the date treatment was initiated for the diagnosis (including the last day in the current billing period).

- Number of Visits - The total number of patient visits completed since OPT services were initiated by you for the diagnosis being treated. Give the total visits to date (including the last visit in the billing period) rather than for each separate billing (value code 50).

- Date of Onset (Occurrence Code 11) - The date of onset of the primary PT diagnosis for which OPT services were rendered by you.

- Date Treatment Started (Occurrence Code 35) - The date OPT services were initiated by you for the primary PT Dx treated.

- Billing Period - When OPT services began and ended in the billing period (from through dates).

C. Level II Review Process.--If a bill exceeds the limit set in the edits, represents a diagnosis other than one on the edits, or the intermediary reviews at a 100 percent level, the bill is referred to the Level II MR staff.

A bill selected for MR is reviewed in conjunction with the medical information you submitted.

1. Reimbursable PT Services.—OPT services may be reimbursed only if they meet all requirements established by the Medicare guidelines and regulations. Each bill for OPT services subjected to Level II or III MR must be supported with adequate medical documentation.

2. MR and Documentation.—The following data elements must be submitted in addition to those used for Level I review:

- Medical History - Submit only the medical history which is pertinent to, or influences the OPT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OPT, and any pertinent prior PT treatment.

- Physician Referral and Date -

- PT Initial Evaluation and Date -

- Plan of Treatment and Date Established -

- Date of Last Certification - The date on which the plan of treatment was last certified by the physician.

- Progress Notes - Updated patient status reports concerning the patient's current functional abilities/limitations.

The information is used along with that in subsection B, to assess the appropriateness of the OPT plan of treatment and the patient's progress. The medical information supporting a bill must be specific. Documentation written in general terms, e.g, "strength appears to have increased" or "can now reach higher overhead" or "medical history-chronic arthritis" is insufficient. To make an informed MR decision the intermediary will request documentation when you submitted incomplete or inadequate documentation. This information is obtained from you regardless of the document type you keep (i.e., it does not matter whether the baseline evaluation is part of the treatment plan, the progress notes or the medical history, intermediaries obtain and use this information in their review. Submit the physician's pertinent evaluations, progress notes and opinions about the patient's need for rehabilitation services when they are available.

3. Medical History.--If a history of previous PT treatment is not available, you may provide a general summary regarding the patient's past relevent medical history recorded during the initial evaluation or through contact with the referring physician. Provide information regarding prior history and treatment by the referring physician when available.

The patient's medical history, as it relates to the OPT, must include the date of onset and/or exacerbation of the illness or injury. If the patient has had prior OPT for the same condition, the history, in conjunction with the patient's current assessment is used by the intermediary to establish whether additional treatment is reasonable.

The history of treatments is also necessary for patients who have transferred to a new provider for additional treatment. For example, if surgery has been performed, inform the intermediary of the type and date of surgery. The date of onset and type of surgical procedure should be specific for diagnoses such as fractured hip. For other diagnoses, such as arthritis, the date of onset may be general and can be established from the date the patient first required medical treatment. For other types of chronic diagnoses, give the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OPT. For example, a patient who had an amputation several years ago might recently have been fitted with a new prosthesis.

4. Evaluation.—Submit a PT initial evaluation, (excluding routine screening) when it is reasonable and necessary to determine if there is an expectation that either restorative or maintenance services will be appropriate for the patient's condition. Submit reevaluations when the patient exhibits a demonstrable change in physical functional ability which requires reevaluation in order to reestablish appropriate treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs. Initial evaluations or reevaluations that are determined reasonable and necessary based upon the patient's condition, may be approved by the intermediary even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The PT evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's condition forms the basis for the PT treatment goals.

Include in your evaluation (when possible) objective tests and measurements which normally include functional, strength, and ROM assessments. However, for patients with certain neurological conditions (such as upper motor neuron conditions) assessment of strength may not be valid. Where these tests are not applicable, the physical therapist should document the patient's functional loss and the need for skilled OPT intervention resulting from conditions such as:

o Self-Care Dependence - The individual is dependent upon skilled assistance or supervision from another person in self-care activities. These activities include, but are not limited to, signficant functional loss or loss of previous functional gains in the ability to:

- Drink;
- Feed;
- Dress; or
- Maintain personal hygiene.

Additionally, this could include care of braces or other adaptive devices.

o Mobility Dependence - The individual is dependent upon another person for skilled OPT assistance or supervision in such areas as transfer, gait deviation, stair climbing, and wheelchair maneuvering due to, but not limited to:

- Decreased strength;
- Marked muscle spasticity;
- Moderate to severe pain;
- Contractures;
- Incoordination;
- Perceptual motor loss;
- Orthotic need; or
- Need for ambulatory or mobility device.

This could involve patients with or without impairment of the lower leg who are partially independent with wheelchair and/or who have significant architectural or environmental barriers.

o Safety Dependence/Secondary Complications - A safety problem exists when a patient cannot handle him/herself without skilled assistance in a manner that is physically safe. This may extend to the performance of activities of daily living or to acquired secondary complications which could intensify medical sequelae such as fracture nonunion, or decubiti. Some examples of safety dependence are high probability of falling, swallowing difficulties, severe loss olf pain, or skin sensation, progressive joint contracture, and infection requiring skilled PT intervention to protect the patient from further complication.

Each patient's condition calls for assessments which are unique to specific impairments. For example, documentation in the treatment of open wounds or ulcerations requires other objective and subjective documentation, such as size and depth of the wound, amount and frequency of drainage, signs of granulation, or evidence of infection, etc.

If the goal for a patient is to increase functional abilities, ROM, or strength, the initial evaluation must measure (if at all possible) the patient's starting functional abilities, ROM and strength. If the assessment indicates that joint ROM or strength is normal, there

there should be evidence of this assessment in the initial evaluation or progress notes, e.g., "within normal limits." If objective documentation cannot be accomplished for any reason, note this in the inital evaluation or progress notes along with the reason(s).

5. Plan of Treatment.--The PT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The plan of treatment must include modalities/procedures, frequency, and duration of treatment. The modalities/procedures must be specific. Submit changes in the plan of treatment with the progress notes.

The plan of treatment must contain the following information:

- Type of Modalities/Procedures - Describe the specific nature of the therapy to be provided. Some examples of PT modalities/procedures are deep heat (e.g., diathermy, ultrasound), superficial heat (e.g., hot packs, whirlpool), and therapeutic exercises and gait training.

- Frequency of Visits - Provide an estimate of the frequency of treatment to be rendered (e.g., 3x week).

- Estimated Duration - Identify the length of time over which the services are to be rendered. It may be expressed in days, weeks, or months.

- Diagnoses - Document the PT disorder/diagnosis if different from the medical diagnosis. For example, the medical diagnosis might be "rheumatoid arthritis." However, the shoulder might be the only area being treated, so the PT diagnosis might be "adhesive capsulitis." In order to establish the PT diagnosis, diagnostic tests are strongly advised.

- Functional Goals - Document the physical therapist's and/or physician's description of what the patient is expected to achieve as a result of therapy.

- Rehabilitation Potential - Document the therapist's and/or physician's expectation concerning the patient's ability to meet the goals at initiation of treatment.

6. Progress Reports (Status Summary(s) Related to the Billing Period).--Provide treatment information regarding the current status of the patient during the billing period. Update in the PT progress notes and any needed reevaluation(s) the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, document it in accordance with §205.3. Additionally, when a patient is continued from one billing period to another, reflect in the progress report(s) a comparison between the patient's current functional status and that of the previous billing and/or at the initial evaluation.

Where a valid expectation of improvement exists at the time OPT services are initiated, or thereafter, reasonable and necessary services are covered even though the expectation may not be realized. However, in such instances, the OPT services are covered only until no further significant functional improvement can be reasonably expected. Document in progress reports or status summaries the continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time. "Significant," in this context, means a generally measurable and substantial increase in the patient's present level of physical functional abilities compared to their level at the time treatment was initiated.

Do not interpret the term "significant" so stringently that you do not submit a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. Intermediaries approve claims if the services are reasonable and necessary and if there is a reasonable expectation that significant improvement in the patient's overall safety or functional ability will occur. However, the physical therapist and/or physician must document such lack of progress and explain the need for continued skilled PT intervention.

Medical review of rehabilitation claims is conducted with an understanding that skilled intervention may be needed, and improvement in a patient's condition may still occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit self care, mobility and/or safety dependence requiring PT services. The fact that full or partial recovery is not possible or rehabilitation potential is not present, is not the deciding factor. The deciding factor is based on whether the services are reasonable effective treatment for the patient's condition and require the skills of a physical therapist, or whether they can be safely and effectively carried out by nonskilled personnel, without the physical therapist's supervision. Clearly describe the reasons for physical therapy intervention in the submitted documentation, as well as the goals of such care.

It is essential that the physical therapist document the updated status in a clear, concise, and objective manner. Stress objective tests and measurements when practical. The physical therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatments duration. If the method used to demonstrate progress is changed or comparable measures are used, document the reasons, including how the new method relates to the old. The intermediary must have an overview of your treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

While objective documentation often necessitates ROM, strength, and other objective measurements; documentation of the patient's current functional status compared to previous reporting period(s) is of paramount importance. Document the deficits in functional ability in order that correct MR decisions may be made.

Physical therapists must document functional improvements (or lack thereof) as a result of their treatments. Document functional progress whenever possible in objective, measurable terms. The following illustrates these principles:

- Pain - Describe the presence or absence of pain and its effect on the patient's functional abilities. Submit a description of the intensity, type, changing pattern, and location at specific joint ROM to materially aid MR decisions. Describe the limitations placed on the patient's self care, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

Transcutaneous electrical nerve stimulation (TENS) is a technique using surface electrodes and electrical current to interrupt pain pathways and sensation of pain through peripheral nerves. Generally, it is covered on a trial basis for up to 1 month. Document any trial period extending beyond 1 month as to reason and medical necessity. These claims may be approved only when your documentation supports the need to assess the patient's suitability for continued treatment with TENS. Once it is determined that TENS should be continued as therapy and the patient has been trained to use the stimulator; it is expected that the stimulator will be employed by the patient in his home. Payment may be made under the prosthetic devices benefit for the TENS stimulator. Payment may not be approved for continued OPT treatments with TENS. (See Coverage Issues Manual 35-46 and 65-8.)

- Therapeutic Exercise - Your documentation must support the skilled nature of the exercise program, and/or the need for design and establishment of a maintenance exercise program. The goals should be to increase functional abilities in self care, mobility or patient safety. Document the goals and type of exercise provided and the major muscle groups treated.

Submit claims when the therapeutic exercise, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by, or under the supervision, of a physical therapist. For example, while passive and active assistive exercise may be performed safely and effectively by nonskilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled PT intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or therapy notes. Include the patient's losses and/or dependencies in self care, mobility and safety. The possibility of adverse effects from improper performance of an otherwise unskilled service does not make it a skilled service. Provide documentation that supports why skilled PT is needed for the patient's medical condition and/or safety.

Submit claims that document establishment and design of a needed maintenance exercise program to fit the patient's level of ADL, function, and needed instruction to the patient, supportive personnel and/or family members to safely and effectively carry out the program. Reevaluation may be approved when your documentation indicates it is reasonable and necessary for readjusting the maintenance program to meet the patient's changing needs. Provide justification for readjusting a patient's maintenance program, e.g., loss of previous functional levels.

- Cardiac Rehabilitation Exercise - Physical therapy is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there also is a diagnosed noncardiac condition requiring therapy, e.g., where a patient who is recuperating from an acute phase of heart disease had a stroke which requires physical therapy. (While the cardiac rehabilitation exercise program may be considered by some a form of PT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.) Restrictions on coverage of PT do not affect rules regarding coverage or noncoverage of such services when furnished in a hospital inpatient or outpatient setting.

- Gait Training - Document that the skilled gait training is designed to restore functional abilities (or to design and establish a safe maintenance program) which can reasonably be expected to improve the patient's ability to walk or walk more safely. Clarify the patient's gait deviation, current functional limitations, and/or safety dependence during gait. Identify the gait problem being treated, e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenberg gait. Submit the type of gait deviation requiring skilled intervention, the functional limitations in mobility and/or safety dependence, the patient's understanding or lack of understanding of the gait training, the amount of assistance needed during gait and the distance the patient is able to walk. Gait training may be approved only when your documentation differentiates skilled gait training rendered from assistive walking, when the patient is walking repetitiously and merely improving distance or endurance (assistive or nonassistive).

- Transfer Training - Describe the patient's current functional limitations in transfer ability that warrant skilled PT intervention. Include the special transfer training needed and rendered, and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Transfer training may be approved only when your documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the task.

If your documentation supports only repetitious carrying out of the transfer method, once established and monitored for safety and completion of the task, it will be considered noncovered care.

- Electrical Nerve Stimulation - Submit claims for reasonable and necessary electrical stimulation to delay or prevent disuse atrophy, but only where your documentation indicates that the nerve supply (including brain, spinal cord and peripheral nerves) to the muscle is intact, and other nonneurological reasons for disuse are causing atrophy. (See Coverage Issues Manual §35-77.)

Electrotherapy for the treatment of facial nerve paralysis, e.g., Bell's palsy is not a covered service. (See Coverage Issues Manual §35-72.)

Submit claims for functional electrical stimulation (FES) used to test the suitability for improving the patient's functional ability when documented in the PT notes as lost. For example, to stimulate the dorsiflexors of the ankle, thereby reducing toe drag during the swing-through phase of gait. Document the functional limitations for which FES is used.

o Biofeedback Therapy - Submit claims when your documentation indicates that it is reasonable and necessary for the patient for muscle reeducation of specific muscle groups, or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

If your documentation only supports treatment for ordinary muscle tension states or for psychosomatic conditions the claim will not be approved. (See Coverage Issues Manual §35-27.)

o Fabrication of Temporary Prostheses, Braces, and Splints - Submit claims for reasonable and necessary fabrication of temporary prostheses, braces and splints, and any reasonable and necessary skilled training needed in their safe and effective use. Indicate the need for the device and training, documenting the patient's functional limitations.

D. Certification and Recertification.--PT services must be certified and recertified by a physician to meet Medicare guidelines. They must be furnished while the patient is under the care of a physician. The OPT services may be furnished under a written plan of treatment established by the physician or a qualified physical therapist providing them; however, if the plan is established by a physicial therapist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or you when you make a written record of the oral orders) before treatment is begun. When OPT services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Obtain the recertification at the time the plan of treatment is reviewed since the same interval is required for the plan's review. Any changes to the treatment plan established by a physical therapist must be in writing and signed by the physical therapist or by the attending physician. Recertifications must be signed by the physician who reviewed the plan. The physician may change a plan of treatment established by the physical therapist, the physical therapist may not alter a plan of treatment established by a physician.

E. Physical Therapy Forms.--Documentation may be submitted on a specific form or may be copies of your original record. Your intermediary may require a specific form if it finds it more efficient than using your records; however, the form must capture the required MR information. If your intermediary chooses to require a specific form, it shows the OMB clearance number. Your information must be complete. If it is not, your intermediary will return the bill for additional information. The intermediary requires the same information that a physical therapist does to properly treat the patient.

F. Post-Pay Sample.--Intermediaries review a random sample of the bills that pass all edits.

Your intermediary conducts a post-pay MR on each claim selected in the random sample. It determines your denial rate by combining the prepay and postpay denials for the same quarter. The rate is calculated by dividing your total charges that the intermediary has determined noncovered by the total charges submitted by you in that quarter. Providers having a 5 percent or higher denial rate in any quarter are placed on 100 percent prepay MR in the subsequent quarter. Providers with a denial rate of less than 5 percent for two (2) consecutive quarters may be removed from 100 percent MR. New providers are handled according to the intermediary's existing procedures.

Your intermediary may also investigate abnormal trends uncovered during the random post-pay sample review. It alerts the RO to its findings, along with its recommendations.

EXHIBIT I
OUTPATIENT PHYSICAL THERAPY EDITS

The following edits are not based on normative treatment. Intermediaries are prohibited from denying a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR or paying bills reviewed at Level I review.

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	**Duration** (MO.)
1.	CA (category A)	162.0-163.9	7	1
	CA (category B)	165.0-165.9	24	2
		170.0-172.9		
		174.0-174.9		
		191.0-192.9		
		195.3-195.8		
		201.0-201.9		
		225.0-225.9		
		238.0-238.1		
		239.6		
2.	Parkinson's Disease	332.0-332.1	13	1
3.	Meningitis/Encephalitis	320.0-323.9	16	2
	Intracranial and intraspinal abcess	324.0-324.9		
	Huntington's Chorea and other choreas	333.4-333.7		
	Spinocerebellar disease	334.0-334.9		
	ALS and other motor neuron diseases	335.2-335.9		
	Other diseases of the spinal cord	336.0-336.9		
	Multiple Sclerosis	340		
	Demyelinating Diseases of CNS	341.8-341.9		
	Hemiplegia (old)	342.0-342.9		
	Paralytic syndrome	344.0-344.9		
	Late effects of CVA	438		
4.	Cerebral hemorrhage, occlusion, stenosis	430-434.9	32	3
	CVA, acute	436		
	Concussion, Loss of consciousness without return to previous level	850.4		
	Intracranial injury including those with skull Fx	800.7-800.8		
		801.7-801.8		
		803.2-803.3		
		803.7-803.8		
		804.7-804.8		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
5.	T.I.A.	435.0	7	1
	Other ill defined cerebrovascular diseases	437.0-437.9		
	Late effects of viral encephalitis	139.0		
6.	Other paralytic syndromes, paraplegia quadriplegia	344.0-344.9	39	3
	FX of vertebral column with spinal cord injury	806.0-806.5 806.8-806.9		
	Spinal cord injury	952.0-952.9		
7.	Post-herpetic polyneuropathy	053.13	19	2
	Neurosyphilis	094.0-094.9		
	Late effects polio	138		
	Diabetes with neurological manifest	250.6		
	Bell's palsy	351.0		
	Disorders of peripheral nerves	353.0-359.9		
	Other peripheral nerve injuries	953.0-957.9		
8.	Diabetes with peripheral circulatory disorders	250.7	13	1
	Diseases of circulatory system	402.0-429.9		
	Raynaud's/Buerger's/PVD	443.0-443.9		
	Thrombophlebitis lower extremity	451.0-451.2		
	Lymphedema	457.0-457.9		
9.	Hansen's Disease	030.0-030.9	29	2
	Gas gangrene	040.0		
	Diabetes with ulcer manifestation	250.8		
	Varicose vein with ulcer	454.0-454.2		
	Cellulitis	681.0-682.9		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
	Other local infection of skin	686.0-686.9		
	Chronic ulcer of skin	707.0-707.9		
	Gangarene	785.4		
	Open wounds	875.0-884.2 890.0-894.2		
	Burns (second degree)	941.2 942.2 943.2 944.2 945.2 946.2 949.2		
	Post traumatic wound infection	958.3		
	Infection of stump	997.62		
10.	Tuberculosis respiratory	010.0-012.8	7	1
	Acute Bronchitis	466.0-466.1		
	Bronchopneumonia	480.0-486.0		
	Bronchitis, emphysema	491.0-492.8		
	Asthma, unspecified	493.9		
	Bronchiectasis	494		
	Chronic airway obstruction	496		
11.	Diffuse disease of connective tissue	710.0-710.9	18	2
	Arthropathy associated with infection	711.0-711.9		
	Arthropathy associated with other disorders	713.0-713.8		
	Rheumatoid arthritis and inflamatory polyarthropathies	714.0-714.9		
	Gouty arthopathy	274.0		
12.	Osteoarthrosis and allied disorders	715.0-716.9	13	1
13.	TMJ disorders	524.6	13	1
	Internal derangement of joint, other derangement of joint and other unspecified disorders of joint	717.0-719.9		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
14.	Dorsopathies	720.0-724.9	13	1
	Osteoporosis	733.0		
	Pathological Fx	733.1		
	Aquired spondylolisthesis	738.4-738.5		
	Anomalies of spine	756.10-756.12		
15.	Peripheral enthesopathies and allied syndromes disorders of muscles, tendons and their attachments and other soft tissues	725-729.9 (excluding 727.1 and 727.4)	13	1
16.	Gait disturbances due to weakness, incoordination debility and/or after surgery or Fx	780.7 739.6 781.2 799.3 V66.4	13	1
17.	Fx of vertebral column without cord injury	805.0-805.9	14	1
	Late effects of Fx spine	905.1		
18.	Fx of pelvis	808.0-808.9	18	2
	Fx of femur	820.0-821.39		
19.	Fx of patella	822.0-822.1	18	2
	Fx of tibia and fibula	823.0-823.9		
	Fx of ankle, tarsals, metatarsals	824.0-825.39 827.0-827.1		
20.	Fx of humerus	811.0-819.1	18	2
	Fx of radius and ulna			
	Fx of carpals			
	Fx of metacarpals and phalanges			
	Fx of radius and ulna			

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
21.	Dislocations	830.0-839.9	18	2
	Crushing injury	927.0-929.9		
22.	Sprains and strains	840.0-848.9	13	1
	Late effects of strains, sprains, dislocations	905.6-905.7		
	Contusions	922.0-924.9		
	Injury, other unspecified	959.1-959.9		
23.	Amputation	885.0-887.7 896.0-897.7	32	3
24.	Burns (3rd and 4th degree)	941.3-941.5 942.3-942.5 943.3-943.5 944.3-944.5 945.3-945.5 946.3-946.5 949.3-949.5	32	3
25.	Joint replacement	V43.6	19	2
26.	Fitting and adjustment of prosthetic care	V52.0-52.1	13	1
	Removal internal fixation device	V54.0		
	Orthopedic aftercare	V54.8-V54.9		
	Late effects FX	905.1-905.5		
	Late effects tendon injury	905.8		
	Late effects amputation	905.9		

502. MEDICAL REVIEW (MR) OF PART B INTERMEDIARY OUTPATIENT SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

These instructions identify documentation requirements for SLP that you must submit to your intermediary for MR. They are flexible in some areas and neither guarantee a minimum amount nor establish a maximum coverage amount. They do not cover all situations.

A. Claims Documentation.--Submit the following information to your intermediary; it must be readable:

- Facility and Patient Identification - (Your name, provider number, patient name, HICN, age).
- Physician Referral and Date.
- Date of Last Certification - The date on which the plan of treatment for SLP was last certified by the physician.
- Diagnosis - List first the primary medical diagnosis for which services were rendered; follow with other applicable diagnoses or which influence care.
- Communication Disorder Diagnosis
- Duration - The total length of time services have been rendered (in days) from when you initiated them for the communication disorder diagnosis (include the last day in the current billing period).
- Number of Visits - The total number of patient visits completed since you initiated services for the communication disorder diagnosis. Give the total visits to date (include the last visit in the billing period) rather than for each separate billing.
- Date of Onset - (Occurrence Code 11) - The date of onset or exacerbation of the communication disorder diagnosis for which you provide services.
- Date Treatment Started - (Occurrence Code 35) - The date you initiated services.
- Billing Period - When services began and ended in the billing period (from-through dates).
- Medical History - Submit only the medical history which is pertinent to, or influences the treatments or tests rendered. Include a brief description of the functional status of the patient prior to the onset of the condition requiring services and any pertinent prior treatment.

- Initial Assessment and Date. (At your location.)
- Plan of Treatment and Date Established. (At your location.)
- Progress Notes - Submit updated patient status reports concerning the patient's current functional communication abilities/limitations.

1. Medical History.--If a history of previous SLP treatment is not available, provide a general summary regarding the patient's past relevent medical history recorded during your initial evaluation with the patient/family (if reliable) or through contact with the referring physician. Provide information regarding prior SLP treatment for the current condition, progress made, and reports of treatment by the referring physician when available. Describe the level of function prior to the current exacerbation or onset.

The patient's medical history, as it relates to SLP, must include the date of onset and/or exacerbation of the illness or injury.

Submit the history of treatments from a previous provider for patients who have transferred to you for additional treatment. Be specific. For chronic conditions, give the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled SLP.

2. Assessment.--Submit an initial assessment when it is reasonable and necessary for the speech-language pathologist to determine if there is an expectation that either restorative services or establishment of a maintenance program will be appropriate for the patient's condition. Reassessments are covered only if the patient exhibits a change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated SLP services. Periodic routine reassessments (e.g., monthly, bimonthly) for a patient undergoing a SLP program are considered a part of the treatment session and are not covered as separate assessments. Submit an initial assessment or reassessment when it is reasonable and necessary based on the patient's condition, even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals.

The initial assessment must include objective baseline diagnostic testing (standarized or nonstandardized), interpretation of test results, and clinical findings. If baseline testing cannot be supplied for any reason, this should be noted in the initial assessment or progress notes along with the reasons. The assessment must also include a statement of the patient's expected rehabilitation potential.

3. Plan of Treatment.--The plan of treatment must contain:

- Type and nature of care to be rendered;
- Functional goals and estimated rehabilitation potential;

- Treatment objectives;
- Frequency of visits; and
- Estimated duration of treatment.

a. Functional Goals.--Functional Goals must be written by the speech-language pathologist to reflect the level of communicative independence the patient is expected to achieve outside of the therapeutic environment. The functional goals must reflect the final level the patient is expected to achieve, be realistic, and have a positive effect on the quality of the patient's everyday functions.

Factors may change or influence the final level of achievement. If this occurs, explain the factors which led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status.

- Communicate personal self-care needs.

- Engage in social communicative interaction with immediate family or friends.

- Carry out communicative interations in the community.

NOTE: The term "communication" includes speech and language, as well as voice skills.

A functional goal may reflect a small, but meaningful change which enables the patient to function more independently in a reasonable amount of time. For some patients it may be the ability to give a consistent, functional "yes" and "no" response; for others it may be the ability to demonstrate a competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phrases; and still others may regain conversational language skills.

b. Treatment Objectives.--Document the specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

c. Frequency of Visits.--Estimate the frequency of treatment to be rendered (e.g., 3x/week).

Rarely, except during an assessment, should session length be longer than 30 to 60 minutes. If longer times are used, justify them by noting that the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average, or special staff/family training is required.

d. Estimated Duration of Treatment.--Identify the total estimated time over which the services are to be rendered. It may be expressed in days, weeks or months.

4. Progress Reports (Treatment Summary for Billing Period).--Document and report:

- The initial functional communication status of the patient at your provider setting;
- The present functional status of the patient for this reporting period;
- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement exists at the time services are initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, they are covered only until no further significant practical improvement can be expected. Your progress reports must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to when treatment was initiated. Do not interpret the term "significant" so stringently that you do not submit a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. Submit the claim if there is still a reasonable expectation that significant improvement in the patient's overall functional ability will occur. However, the speech-language pathologist and/or physician must document such lack of progress and explain the need for continued intervention.

Include a short narrative progress report and objective information in a clear, concise manner. This provides the intermediary with evidence of the patient's progress in meeting the plan of treatment, along with any changes in the goals or treatment plan. Attach new plans to the original. However, ensure that an overall treatment plan with final goals and enough objective information is present with each claim to indicate progress toward meeting all goals.

Consistent reporting is important. For example, if you report that the patient can produce an "m" 25 percent of the time, and later report 40, 60, 90 percent, the intermediary may believe the treatment is ending. Document the final goal and the objectives to clarify the progress toward the final goal and the steps needed to reach it.

The speech-language pathologist might state that the final goal is "the ability to converse in a limited environment." One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors." The short-term goals demonstrate that the patient's ability to initiate easier phonemes comes before other more difficult phonemes. The speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might choose to work on a group of phonemes having a "feature" in common before another group. For example, working on all bilabials (since the patient can easily see the movement), might be desired prior to sounds that are produced more intraorally.

You may choose how to demonstrate progress. However, the method chosen, as well as the measures used, should generally remain the same for the duration of treatment. Interpret reports of test scores or comparable measures and their relationship to functional goals in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to demonstrate progress is changed, document the reasons. Include how the new method relates to the previous documentation. Avoid reporting a subtest score for 1 month, then a score of a different subtest the next month without demonstrating either the goals or the subtest's interrelationship. They will be returned to you for explanation/interpretation.

5. Level of Complexity of Treatment.--Document the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement, however, it is the speech-language pathologist's analysis that makes the activity skilled.

6. Reporting of New Episode or Condition.--Occasionally, a patient receiving, or who has previously received SLP services, experiences a new illness. Document the significance of any change to the communication capabilities. Provide any pertinent pre- or post episodic objective documentation, in nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient has completed treatment, document the significant change in the communication status that warrants a new treatment plan.

7. Qualified Speech-Language Pathologist.--

- A person who is licensed, if applicable, by the State in which he/she is practicing; and
- Is eligible for a certificate of clinical competence in SLP granted by the American Speech-Language-Hearing Association; or:

-- Meets the educational requirements for certification, and is in the process of accumulating the required supervised experience.

o The speech-language pathologist normally indicates certification status by utilizing CCC-SLP or CFY-SLP:

-- CCC-SLP Certificate of Clinical Competence in SLP; or
-- CFY-SLP Clinical Fellowship Year in Speech-Language Pathology.

8. Certification and Recertification.--SLP services must be certified and recertified by a physician. They must be furnished while under the care of a physician, and furnished under a written plan of treatment established by the physician or a qualified speech-language pathologist providing the services. If the plan is established by a speech-language pathologist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or you when you make a written record of the oral orders) before treatment is begun.

When outpatient SLP services are continued under the same plan of treatment, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Recertifications must be signed by the physician who reviews the plan of treatment. Any changes to the treatment plan established by the speech-language pathologist must be in writing and signed by the speech-language pathologist or by the attending physician. The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

B. Examples of Skilled and Unskilled Procedures.--

1. Skilled Procedures.--

o Diagnostic and assessment services to ascertain the type, causal factor(s) and severity of speech and language disorders. Reassessment, if the patient exhibits a change in functional speech or motivation, clearing of confusion, or remission of some other medical condition which previously contraindicated SLP services.

o Design of a treatment program relevant to the patient's disorder(s). Continued assessment of the patient's progress during the implementation of treatment, including documentation and professional analysis of the patient's status at regular intervals.

o Establishment of compensatory skills (e.g., air-injection techniques, word finding strategies).

- Establishment of a hierarchy of speech-language tasks and cueing that directs a patient toward communication goals.

- Analysis related to actual progress toward goals.

- Patient and family training to augment restorative treatment or to establish a maintenance program.

2. Unskilled Procedures.--

- Nondiagnostic/nontherapeutic routine, repetitive and reinforced procedures (e.g., the practing of word drills without skilled feedback).

- Procedures which are repetitive and/or reinforcing of previously learned material which the patient or family is instructed to repeat.

- Procedures which may be effectively carried out with the patient by any nonprofessional (e.g., family member, restorative nursing aide) after instruction and training is completed.

- Provision of practice for use of agumentative or alternative assessment communication systems.

NOTE: It is only after the patient has established a high level of consistency of performance in a task with the speech-language pathologist, that unskilled techniques can be implemented.

C. Examples of Statements Supporting and Not Supporting Coverage.--

1. Statements Supporting Coverage.--Typically these have an objective component, which is compared to previous reporting, and which demonstrate progress toward a stated functional goal.

EXAMPLES: "Mr. Smith achieved 75 on the word subtest on the Johnson Test of Aphasia compared with last month's care of 50 on the same subtest."

"Mr. Jones achieved a combined score of 352 on the A, B, C D, and E subtests this month compared with an overall score of 250 for these SAME subtests last month."

"Mrs. Jones achieved the next steps in the treatment plan outlined last month (see attached sheet). If she continues at this rate, she should complete treatment within the next 2 months."

"Mrs. Jones achieved 75% (7.5 out of 10 or 75 out of 100) on word naming this compares to last month's score of 50% (5.0 out of 10 or 50 out of 100)."

NOTE: Percent should be based on real number count. Interpretation of scores must be presented in progress notes or summary information. Your narrative should contain reference to objective scoring, comparison to previous scores, or to the treatment plan with present status compared to previous status. Provide this information and the functional goal in narrative or as an attachment.

2. Statements Not Supporting Coverage.--Typically, these statements are subjective, do not demonstrate progress toward a stated functional goal, or a comparison to previous test scores.

EXAMPLE: "Mrs. Jones is very concerned about going home. She has begun smoking again which is causing family problems as well as physical problems."

"Speech somewhat slurred today."

"Mr. Smith more consistent in responses."

"Mr. Jones has shown significant improvement in his ability to make himself understood."

"Patient is now able to inject air 80% of the time."

"Mrs. Smith achieved 75% accuracy on word naming task. (No comparison to previous report)."

"Auditory comprehension improved from moderately impaired to mildly impaired (by itself, does not offer sufficient objective information)."

D. Resumption of Treatment.--Document the patient's conditions and circumstances that justify resuming treatment after it has been delayed. Examples include:

- o Patient became more alert, attentive, cooperative;
- o Patient shows rehabilitation potential;
- o Medical complications cleared;
- o Environmental change improves motivation or communicative capabilities;
- o Progressive nature of disorder warrants further treatment; and
- o Drug or other medical treatment is reduced or ended.

502.1 Other MR Considerations.--

A. Disorders Typically Not Covered for the Geriatric Patient.--

- o Stuttering (except neurogenic stuttering caused by acquired brain damage)

Fluency Disorder
Cluttering
Disprosody
Disfluency

- Myofunctional Disorders

Tongue Thrust

- Behavior/Psychological Speech Delay

B. Maintenance.--Submit claims when the specialized knowledge and judgment of a qualified speech-langage pathologist is required to design and establish a maintenance program. By the time the patient's restorative program has been completed, the maintenance program has been designed, with instructions to patient, supportive personnel, or family. Do not submit a separate charge for establishing the maintenance program immediately after the restoration program has been completed.

Provide adequate treatment justification for reestablishing a maintenance program, e.g., loss in previous functional abilities occurs, intervening medical conditions develop, or recent difficulty in communicating with caregivers arises.

Document the initial assessment using standardized testing (if possible) to establish baseline data. This is critical if the patient returns for care at a future date. Show that the maintenance program is designed by the qualified speech-language pathologist appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician.

Your maintenance program will be considered established when it has been designed to fit the patient's level of function and when instructions to the patient and supportive personnel have been completed sufficient for them to safely and effectively carry it out. Give reasonable assurances that this has occurred. After that point, the services will not be considered reasonable and necessary.

C. Group or Individual Treatment.--Generally, group treatment and social or support groups such as stroke clubs or lost cord clubs are not reimbursable.

D. Total Laryngectomy.--A total laryngectomy is the surgical removal of the larynx. Documentation may involve pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about alternative communication methods, and to provide an immediate means of communication following surgery. Include assessment and a description of any reasonable and necessary treatment to establish a means of communication using esophageal speech, an artificial larynx (electronic or pneumatic device), a tracheoesophageal puncture prosthesis, and/or other alternate communication methods.

E. Partial Laryngectomy.--A partial laryngectomy is the surgical removal of part of the larynx. Documentation includes voice problems that require assessment and treatment. It may involve pre-op/post-op sessions as part of the assessment, and to inform the patient, the family, and staff about voice problems. Include the assessment, type of treatment for the voice disorders, including base-line objective data and progress notes.

F. Total Glossectomy.--Total glossectomy is the surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. It may include pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery and/or to establish an effective maintenance program. Documentation includes assessment and type of treatment for the articulation disorders. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

G. Partial Glossectomy.--Partial glossectomy is the surgical removal of part of the tongue. Documentation should indicate the articulation problems that require assessment and treatment. It may include pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery. Documentation includes the assessment and type of treatment for the articulation disorders including base-line objective data and progress notes. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

H. Congential Disorders.--Your documentation must substantiate need, e.g., no previous treatment; the patient's speech-language communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected SLP communication. Submit claims for maintenance or short-term treatment only if your objective documenation supports a reasonable and necessary need.

I. Alzheimer's Disease.--(Chronic brain syndrome, organic brain syndrome). Your objective documentation must indicate the patients' condition, alertness and mental awareness. Justify that services are needed for establishment of a maintenance program.

J. Chronic Conditions.--Submit claims for patients with chronic conditions such as MS, ALS, Parkinson's Disease or Myasthenia Gravis when you document a need for short-term care or establishing a maintenance program. Submit clear documentation concerning any prior care or maintenance program for the same condition. Submit claims for short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, only when your documentation supports the need to increase function or to establish a maintenance program.

503. MEDICAL REVIEW OF FOR PART B INTERMEDIARY OUTPATIENT OCCUPATIONAL THERAPY (OT) SERVICES

These instructions specify the requirements for OT claims that you must submit to your intermediary for MR. They are, in some areas, flexible and neither guarantee a minimum amount of coverage nor establish a maximum coverage amount. They do not cover all situations.

Submit the following information to your intermediary; it must be readable:

- Facility and Patient Identification - (Your name, patient name, provider number, HICN, age).
- Physician Referral and Date.
- Date of Last Certification - The date on which the plan of treatment was last certified by the physician.
- Diagnosis - List first the primary diagnosis for which OT services were rendered; follow with other applicable diagnoses or those that influence care.
- Duration - The total length of time OT services have been rendered (in days) from the date you initiated them (include the last day in the current billing period).
- Number of Visits - The total number of patient visits completed since OT services you initiated for the diagnosis being treated. Give the total visits to date (include the last visit in the billing period) rather than each separate billing.
- Date of Onset (Occurrence Code 11) - The date of onset of the primary OT diagnosis for which you rendered OT services.
- Date Treatment Started (Occurrence Code 35) - The date you initiated OT services for the primary OT diagnosis being treated.
- Billing Period - When OT services began and ended in the billing period (from-through dates).
- Medical History - Submit only pertinent medical history, or which influences the OT treatment. Include a brief description of the patient's functional status prior to the onset of the condition requiring OT and any pertinent prior OT treatment.

- o OT Initial Evaluation and Date. (At your location.)

- o Plan of Treatment and Date Established.

- o OT Progress Notes - Submit updated status reports concerning the patient's current functional abilities/limitations.

1. Medical History.--If a history of previous OT treatment is not available, you may provide a general summary regarding the patient's past relevent medical history obtained during the initial evaluation with the patient/family (if reliable) or through contact with the referring physician. Provide information regarding prior OT treatment for the current condition, progress made, and treatment by the referring physician when available. Describe the level of function prior to the current exacerbation or onset.

Include in the patient's medical history, the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, submit that history with the patient's current assessment.

Submit the history of treatments from a previous provider for patients who have transferred to you. If a surgical procedure is involved, state the date and the name of the surgical procedure. For other diagnoses, such as arthritis, the date of onset (if unknown) may be the date the patient first required medical treatment. For other types of chronic diagnoses, document the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OT.

2. Evaluation.--Submit the initial OT evaluation, (exclude routine screening) when it is reasonable and necessary to determine if there is an expectation that either restorative or maintenance services will be appropriate. Submit reevaluations when the patient exhibits a demonstrable change in physical functional ability necessitating revised treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs.

Initial evaluations or reevaluations determined to be reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed. Submit the physician's pertinent evaluations, progress notes and opinions about the patient's need for rehabilitation services when they are available.

The evaluation must establish the physical and cognitive baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The patient's functional deficits and level of assistance needed forms the basis of the OT treatment goals. Use objective tests and measurements (when possible) to establish base-line data.

Document the patient's functional loss and the level of assistance requiring skilled OT intervention resulting from:

o Activities of Daily Living (ADL) Dependence - The individual requires skilled assistance in handling his/her activities of daily living. These activities include, but are not limited to, signficant physical and/or cognitive functional loss or loss of previous functional gains in the ability to:

-- Feed, eat, drink;
-- Bathe;
-- Dress;
-- Perform personal hygiene;
-- Groom; or
-- Perform toileting.

It could include management and care of orthoses and/or other adaptive equipment, or other customized therapeutic adaptations.

o Functional Limitation - The individual is dependent upon skilled OT intervention in such areas as functional training, observation, assessment, and environmental adaptation due to, but not limited to:

-- Lack of awareness of sensory cues, or safety hazards;
-- Impaired attention span;
-- Impaired strength;
-- Incoordination;
-- Abnormal muscle tone;
-- Range of motion limitations;
-- Impaired body scheme;
-- Perceptual deficits;
-- Impaired balance/head control;
-- Environmental barriers; and

o Safety Dependence/Secondary Complications - A safety problem exists when a patient without skilled OT intervention cannot function in a manner that is physically and/or cognitively safe. This may extend to the activities of daily living or to acquired secondary complications which could intensify medical sequelae such as fracture nonunion, or skin breakdown. Safety dependence may be documented by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal agressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled OT intervention to protect the patient from further medical complications.

If the goal for a patient is to increase functional abilities and to decrease the level of assistance needed, the initial evaluation must measure the patient's starting functional abilities and level of assistance required.

3. Plan of Treatment.--Include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." Include specific OT procedures, frequencies, and duration of treatments. Submit changes in the plan of treatment with the progress notes.

It must contain the following information concerning the OT treatment forwarded to the intermediary:

o Type of Procedures - The specific nature of the therapy to be provided.

o Frequency of Visits - An estimate of the frequency of treatment to be rendered (e.g., 3x week).

o Medical documentation must justify the intensity of services rendered. This is crucial when the treatments will be given more frequently than 3 times a week.

o Estimated Duration - The length of time over which the services are to be rendered. It may be expressed in days, weeks, or months.

o Diagnoses - Document the diagnosis if different from the medical diagnosis. Base the OT diagnosis on objective tests whenever possible.

o Functional OT Goals (Short or Long-Term) - The occupational therapist's and/or physician's description of what functional physical/cognitive abilities the patient is expected to achieve.

Factors may change or influence the final level of achievement. If this occurs, document those which led to the change in functional goal(s).

o Rehabilitation Potential - The occupational therapist's and/or physician's expectation concerning the patient's ability to meet the established goals.

4. Progress Reports (Treatment Summary for Billing Period).--Document and report:

o The initial functional status of the patient;

- The patient's present functional status and progress (or lack of progress) for this reporting period; include clinical findings (amount of physical and/or cognitive assistance needed, range of motion, muscle strength, unaffected limb measurements, etc.); and

- The patient's expected rehabilitation potential.

Where improvement is anticipated when OT services are initiated, or anytime thereafter, the services are covered even though the expectation may not be realized. However, in such instances, the OT services are covered only to the time that no further significant practical improvement can be expected. Document in progress reports or status summaries this continued expectation.

"Significant," means a generally measurable and substantial increase in the patient's present level of functional independence, and competence compared to the level of function at the time treatment was initiated. Do not interpret the term "significant" so stringently that you do not submit a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience a complicating condition or a brief period when lack of progress occurs. Intermediaries approve claims if the services are reasonable and necessary, and if there is still a reasonable expectation that significant improvement in the patient's overall safety or functional ability will occur. However, the occupational therapist and/or physician should document such lack of progress and briefly explain the need for continued skilled OT intervention.

Provide treatment information regarding the current status of the patient during the course of the billing period. Update in progress notes and any needed reevaluation(s) the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, document it in accordance with §242.3. Additionally, when a patient is carried over from one billing period to another, reflect in the progress report(s) a comparison between the patient's current functional status and that obtained during the previous billing and/or the initial evaluation.

Medical review of rehabilitation claims is conducted with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit ADL, mobility and/or safety dependence requiring OT services. The fact that full or partial recovery is not possible or rehabilitation potential is not present, is not the deciding factor. The deciding factor is always whether the services are considered reasonable, effective treatment for the patient's condition and require the skills of an occupational therapist, or whether they can be safely and effectively carried out by nonskilled personnel, without the occupational therapist's supervision. Document the reasons for OT intervention, as well as goals of such care.

It is essential that you document updated status through clear, concise, and objective progress notes. Stress objective tests and measurements when practical. The occupational therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used to demonstrate progress is changed or comparable measures are used; document the reasons for the change, including how the new method relates to the old. The intermediary must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

Documentation of the patient's current functional status and level of assistance required compared to previous reporting period(s) is of paramount importance. The deficits in functional ability must be clear. Occupational therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated whenever possible in objective, measurable terms. The following illustrates these principles and demonstrates that significant changes may occur in one or more of these assistance levels:

a. Change in Level of Assistance.--Document assistance levels by describing the relationship between functional activities and the need for assistance. Within the assistance levels of minimum, moderate, and maximum, there are intermediate gradations of improvement based on changes in behavior and response to assistance. Document improvements at each level. Compare the current cognitive and physicial level achieved to that achieved previously. While the need for cognitive assistance often is the more severe and persistent disability, the requirement of physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Document the levels as follows:

o Total Assistance - Is the need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation.

A patient requires total assistance if your documentation indicates the patient is only able to initiate minimal voluntary motor actions and that the skill of an occupational therapist is required to develop a therapeutic program or to implement a maintenance program to prevent or to minimize deterioration.

A cognitively impaired patient requires total assistance when your documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Document what OT skills are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

o Maximum Assistance - Is the need for 75 percent assistance by one person to physicially perform any part of a functional activity and/or cognitive assistance to perform gross motor actions in response to direction.

A patient requires maximum assistance if your documentation shows that maximum OT physical support and proprioceptive stimulation is needed for performance of each step of an activity, every time it is performed.

Document the specific need for OT proprioceptive stimulation and/or one-to-one demonstration by the occupational therapist due to lack of cognitive awareness of other people or objects in the environment.

o Moderate Assistance - Is the need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely.

Document that your patient requires moderate assistance by indicating that moderate OT physical support and proprioceptive stimulation is needed for the patient to perform a functional activity, every time it is performed.

The records submitted should state how a cognitively impaired patient, at this level, requires intermittent one-to-one demonstration or intermittent cueing (physical or verbal) throughout the performance of the activity. Moderate assistance is needed when your documentation indicates that the therapist/caregiver needs to be in the immediate environment to progress the patient through a sequence to complete a functional activity. Document how this level of assistance is required to halt continuing repetition of a task and to what extent assistance is needed to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

o Minimum Assistance - Is the need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely.

A physically impaired patient requires minimum assistance if your documentation indicates that activities can only be performed after physical set-up by the therapist or caregiver, and if physical help is needed to initiate, or sustain an activity. Document any review of alternate procedures, sequences and methods that may be required.

A cognitively impaired patient requires minimal assistance if your documentation indicates help is needed in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

o Standby Assistance - Is the need for supervision by one person for the patient to perform new activity procedures which were adapted by the therapist for safe and effective performance.

A patient requires standby assistance when errors and the need for safety precautions are not always anticipated by the patient.

o Independent Status - Means that no physical or cognitive assistance is required to perform functional activities.

Your documentation should indicate that patients at this level are able to implement the selected courses of action, consider potential errors and anticipate safety hazards in familiar and new situations.

b. Change in Response to Treatment Within Each Level of Assistance.--Significant improvement in a patient's condition most be indicated by documenting a change in one or more of the following categories of patient responses within any assistance level.

o Decreased Refusals - Document that the patient responds by refusing to attempt performance of an activity because of fear or pain. Document what activity and performance is refused, the reasons, and how the OT plan addresses them.

These responses are often secondary to a change in medical status or medications. If the refusals continue over several days, the therapy program should be put on "hold" until the patient is willing to attempt performance of functional activities.

For the cognitively impaired patient, document refusal to perform that escalates into agressive, destructive or verbally abusive behavior if pressed by the therapist or caregiver to perform. In these cases, a reduction in these behaviors will be considered significant however, these behaviors must be documented, including the skilled OT provided to reduce the abnormal behavior.

For the psychiatrically impaired patient, refusals to participate in an activity frequently are symptoms of the diagnosis. Document the skilled OT rendered, and if the patient is contacted regularly. Describe how the patient is actively encouraged to participate.

o Increased Consistency - Document that the patient responds by inconsistently performing functional tasks from day-to-day or within a treatment session. Document the skilled OT rendered to address this problem.

Document the increase in consistency of performance of functional tasks within the same level of assistance.

o Increased Generalization - The patient may respond by applying previously learned concepts and performance of one activity to another similar activity. Document the increased scope of activities the patient can perform, the type of activities, and the OT services rendered.

c. A New Skilled Functional Activity is Initiated.--Two examples of skilled care:

o Adding teaching of lower body dressing to a current program of upper body dressing;

o Increasing the ability to perform personal hygiene activities for health and social acceptance.

d. A New Skilled Compensatory Technique is Added.--(With or without adapted equipment.) Two examples:

o Teaching a patient techniques such as one-handed shoe tying;

o Teaching the use of a button hook for buttoning shirt buttons.

e. Length of Time in Treatment.--The acceptable length of time in treatment for various disorders is determined by the patient's functional abilities and progress as reflected in your documentation.

5. Level of Complexity of Treatment.--Document the level of complexity of the services rendered by the occupational therapist and not what the patient is asked to do.

Examples of complexity of treatment:

a. Skilled OT.--Indicate that the severity of the physical/emotional/perceptual/cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. In addition, document instructions required by the patient and/or the patient's caregivers. Document the special services provided by an occupational therapist to decrease or eliminate limitations in functional activity performance imposed by illness or disability. Document the underlying factors which interfere with the performance of specific activities. Some of these factors could be cognitive, sensory, or perceptual deficits.

Document how the occupational therapist modified the specific activity by using adapted equipment, making changes in the environment and surrounding objects, altering procedures for accomplishing the task, and providing specialized assistance to meet the patient's current and potential abilities. Skilled services include, but are not limited to reasonable and necessary:

- Evaluations of the patient;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professsionals;
- Analyzing and modifying functional tasks (document the tasks involved);
- Determining that the modified task obtains optimum performance through tests and measurements;
- Providing instruction of the task(s) to the patient/family/caregivers; and
- Periodic reevaluating the patient's status with corresponding readjustment of the OT program.

Document any period of practice rendered for the patient and/or patient's caregivers to learn the steps of the task, to verify the task's effectivnesss in improving function, and to check for safe and consistent activity performance.

b. Nonskilled OT.--When your documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of an occupational therapist are not required to maintain function at the level to which it has been restored. Examples of maintenance procedures:

- Daily feeding programs after the adapted procedures are in place;
- Routine exercise and strengthing programs;
- The practice of coordination and self-care skills on a daily basis; and
- Presenting information on energy conservation or pacing, but not having the patient perform the activity.

Submit a claim because the patient requires the judgment and skills of the occupational therapist to design a safe and effective maintenance program and make periodic checks of its effectiveness. Do not submit claims where the services of an occupational therapist are used in carrying out the established maintenance program.

6. Reporting on New Episode or Condition.--Occasionally, a patient who is receiving or who has received OT services, experiences a new illness. Document the significance of any change to the patient's functional capabilities. This may be by pre and post episodic through nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient has completed treatment for the functional deficit; document a significant change in the functional status which warrants a new treatment plan.

503.1 Other MR Considerations.--

A. Pain.--Describe the presence or absence of pain and its effect on the patient's functional abilities. Submit a description of its intensity, type, changing pattern, and location at specific joint ranges of motion to materially aid correct MR decisions. Describe the limitations placed upon the patient's ADL, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

B. Therapeutic Programs.--Your objective documentation should support the skilled nature of the program, and/or the need for the design and establishment of a maintenance OT program. The goals should generally be to increase functional abilities in ADL, mobility or patient safety. Document the goals and type of program provided.

Submit claims when the therapeutic program, because of documented medical complications, the condition of the patient, or complexity of the OT employed, must be rendered by, or under, the supervision of an occupational therapist. For example, while functional ADL may often be performed safely and effectively by nonskilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled OT intervention to render the service and/or to establish a safe and effective maintenance program. In these cases, the complications, and the skilled services they require, must be documented by physician orders and/or OT notes. Include the patient's losses and/or dependencies in ADL, mobility and safety. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service. Provide documentation to support why skilled OT is needed for the patient's medical condition and/or safety.

Document establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions supportive personnel and/or family members need to safely and effectively carry it out. Reevaluation may be approved when your documentation indicates it is reasonable and necessary for readjusting the maintenance program to meet the patient's changing needs. Provide adequate justification for readjusting a maintenance program, e.g., loss of previous functional gains.

C. Cardiac Rehabilitation Exercise.--OT is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there also is a diagnosed noncardiac condition requiring it e.g., where a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires OT. (While the cardiac rehabilitation exercise program may be considered by some a form of OT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.)

D. Transfer Training.--Describe the patient's functional limitations in transfer ability that warrant skilled OT intervention. Include the special transfer training needed to perform functional daily living skills and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Transfer training may be approved only when your documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the functional activities of daily living or mobility task.

If your documentation supports only repetitious carrying out of the transfer method, once established and monitored for safety and completion, it will be considered noncovered care.

E. Fabrication of and Training in Use of Orthoses, Prostheses and Adaptive Equipment.--Submit claims for reasonable and necessary fabrication of orthoses, prostheses, adaptive equipment, and any reasonable and necessary skilled training needed in their safe and effective use. Indicate the need for the device and training required, documenting the patient's functional limitations.

F. OT Forms.--Documentation may be submitted on a specific form or may be copies of your original record. Your intermediary may require a specific form if it finds it more efficient than using your records; however, the form must capture the needed MR information. If your intermediary chooses to require a particular form, it shows the OMB clearance number. Your information must be complete. If it is not, your intermediary will return the bill and request the missing information. The intermediary requires the same information that an occupational therapist does to properly treat the patient.

G. Certification and Recertification.--To meet Medicare guidelines, OT services must be certified and recertified by a physician. They must be furnished while the patient is under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified occupational therapist providing such services. If the plan is established by an occupational therapist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or you when you make a written record of the oral orders) before treatment is begun. When OT services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Obtain the recertification at the time the plan of treatment is reviewed since the same interval is required for the plan's review. Recertification must be signed by the physician who reviews the plan of treatment. Any changes to the treatment plan established by the occupational therapist must be in writing and signed by the occupational therapist or by the attending physician. The physician may change a plan of treatment established by the occupational therapist. The occupational therapist may not alter a plan of treatment established by a physician.

503.2 Occupational Therapy Availability.--There may be instances where two or more disciplines are providing therapy services to the same patient. There may also be occasions where these services are duplicative. Your documentation is used by your intermediary to determine if duplication exists. Some examples where there is not a duplication of services:

o Transfers - Physical therapy instructs the patient in transfers to ascertain the level of safety with the techniques. Occupational therapy instructs and utilizes transfers as they relate to the performance of daily living skills, i.e., transfer from wheelchair to bathtub to bathe.

o Pulmonary - Physical therapy teaches the patient an adapted breathing program. Occupational therapy carries the breathing retraining program into activities of daily living training.

o Hip Fractures/Arthroplasties - Physical therapy instructs the patient in hip precautions and gait training. Occupational therapy carries out and reinforces the precautions when training the patient in activities of daily living, e.g., lower extremity dressing, toileting, and bathing.

o CVA - Physical therapy utilizes upper extremity neurodevelopmental (NDT) techniques to assist the patient in positioning the upper extremities on a walker and in gait training. Occupational therapy utilizes upper extremity neurodevelopmental (NDT) techniques to increase the functional use of the upper extremity for dressing, bathing, grooming, etc.

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